5-1997

An Implementation Study of Nonsecure Residential Juvenile Sex Offender Programs in Utah

Katrina Holgate Miller

AN IMPLEMENTATION STUDY OF NONSECURE RESIDENTIAL JUVENILE SEX OFFENDER PROGRAMS IN UTAH

by

Katrina Holgate Miller

A dissertation submitted in partial fulfillment
of the requirements for the degree

of

DOCTOR OF PHILOSOPHY

in

Familly and Human Development

ABSTRACT

An Implementation Study of Nonsecure Residential

Juvenile Sex Offender Programs in Utah

by

Katrina Holgate Miller, Doctor of Philosophy

Utah State University 1997

Main Professor: Dr. D. Kim Openshaw
Department: Family and Human Development

An inventory, the Juvenile Sex Offender Program Provider Implementation Tool (JSSOPIT), was constructed from guidelines stipulated by the Network on Juveniles Offending Sexually (NOJOS), Medicaid, and the Utah Department of Human Services. Seven nonsecure residential programs for juvenile sex offenders in Utah were evaluated with the JSSOPPIT for implementation in six areas: (a) target population, (b) intake criteria and procedures, (c) treatment constellation, (d) supervision, (e) aftercare, and (f) staff qualifications and training. Favorable implementation was found in several areas, including an appropriate risk level in the target population; youths' understanding of treatment goals, treatment regimen, and physical environment; and availability of continuum of care. Unfavorable implementation was found in the area of intake criteria, treatment goal coverage, and tracking recidivism. Results are discussed in terms of the group and individual programs.

(299 pages)

ACKNOWLEDGMENTS

I would like to thank Mr. David Fowers for his help as a partner in the evaluation research. His help, through the Division of Youth Corrections, made possible the research grant that funded this proposal. I would especially like to thank my committee members, Dr. D. Kim Openshaw, Brent Miller, Tom Lee, Byron Burnham, and Carolyn Barcus, for their mentorship and support throughout the dissertation process.

I give special thanks to my husband, Craig W. Miller, and children, Caroline, Conrad, Samuel, Mette, Hiram, and Nathan, for their support and patience. Also, thanks to my friends and neighbors who would give encouraging words. I could not have done it without all of you.

Katrina Holgate Miller

CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1

INTRODUCTION

The treatment of juvenile sex offenders (JSOs) has undergone dramatic and productive changes in recent years. The evolution of treatment began with an initial recognition of the problem on a national level (Barbaree, Hudson, & Seto, 1993) and progressed to an expansion of clinical methods and clinical programs (Freeman-Longo, Bird, Stevenson, & Fiske, 1994). Recently, there has been a recognition of a need to evaluate existing programs to identify factors correlated with lower recidivism rates (National Task Force on Juvenile Sexual Offending, 1993). The national effort toward treatment that decreases recidivism has been paralleled by efforts in the State of Utah (Network on Juveniles Offending Sexually, 1994, 1996).

National Advances in Treatment and Evaluation

Prior to the 1960s, adult sexual offenders were "put away" with the mentally disabled in mental institutions (see Schwartz & Cellini, 1995, p. P1-1.). Not until the 1970s did society generally recognize that adults sexually abused children (Morain, 1994).

In the early 1980s, child-protection workers recognized that adolescents were engaging in sexually abusive behaviors (National Task Force on Juvenile Sexual Offending, 1993; Otey & Ryan, 1983). In the late 1980s, the research literature started reporting on sexual assault by children and preadolescent children (Cantwell, 1988; Cavanaugh-Johnson, 1989; Johnson, 1988). As concern for juvenile sex offending has risen, the number of treatment programs available nationally has increased substantially--from 346 in 1986 to more than 1,000 in 1994 (Freeman-Longo et al., 1994).

There have been two major advances in the field of juvenile sex offender treatment during the past decade. Both of these advances have involved networking among national providers to share information and promote the advancement of treatment. First, two attempts have been made to convene a panel of national experts on juvenile offenders to delineate the state of current knowledge and recommend treatment standards for other practitioners to follow (National Task

Force on Juvenile Sexual Offending, 1988, 1993). Second, the Safer Society has conducted several national surveys of provider's treatment of JSOs to determine what treatments were available nationally and what treatment modalities were being used (Freeman-Longo, et al. 1994). The Safer Society was created by the New York State Council of Churches for the purpose of designing and distributing education/action tools for people working to create a safer society (Knopp, 1982).

Further advances in enhancing efficacious treatment of juvenile sex offenders will involve program evaluation of existing programs. The National Task Force on Juvenile Sexual Offending (1988) suggested that "ongoing program evaluation" be one important element of an ideal intervention. Program evaluation involves both outcome (recidivism) and implementation (process) research. Implementation research identifies what target population was served and how services were delivered (Scheirer, 1994). An understanding of program implementation, when linked with recidivism rates across sites and across time, can help identify characteristics necessary to create optimal interventions for JSOs.

Utah Advances in Treatment and Evaluation

The treatment of JSOs in Utah, like the treatment of JSOs nationally, has undergone dramatic and productive changes in recent years. Network on Juveniles Offending Sexually (NOJOS, 1989), in their research of court documents in the mid-1970s, found less than 20 court referrals for JSOs along the Wasatch Front in any given year (1974-1978). By 1984, the number of court referrals along the Wasatch Front had increased to more than 220. By 1992, 740 juveniles statewide were known to have committed 1,093 sex offenses (Gerdes, Gourley, & Cash, 1995).

Serious attempts to deal with juvenile sex offending began in Utah in 1987, as the Utah Task Force on Juveniles Offending Sexually was created by the Fifth District Juvenile Court (NOJOS, 1989). This task force found tremendous gaps in Utah's resources and delivery of services to juvenile sex offenders, including (a) a general lack of sex offender specific resources;

(b) a lack of understanding by juvenile justice and the public about the harmful nature of juvenile sex offenses; and (c) low usage of existing specialized treatment for JSOs.

The task force saw a need for a major effort that was beyond their scope; hence, a state-wide network, the Utah Network on Juveniles Offending Sexually (NOJOS), was created in 1988. Advances in the treatment of the juvenile sex offender in Utah during the past 10 years have been made possible as experts in NOJOS have networked together to organize knowledge about juvenile sex offending in Utah and use that knowledge to promote community safety through legislative education. Two goals of NOJOS are especially relevant to the purposes of the research considered in this study: (a) the establishment of comprehensive services for juvenile sex offenders, and (b) a collaboration of state and local agencies, both public and private to promote improved treatment practice for JSOs.

Efforts to establish comprehensive services for JSOs were initiated in 1990, when members of NOJOS recommended to the governor of the State of Utah that a "continuum of care" be established for JSOs (Utah Governor's Council, 1990). This plan delineated eight levels of need and risk by severity, ranging from Level One (sex offender is found to be young and naive) to Level Eight (sex offender has average of eight felonies and 18 misdemeanors). Treatment/placement options ranged from Level One (in home with brief counseling and no court involvement) to Level Eight (secure residential). In response to recommendations of The Utah Govenor's Council (1990), the 1992 Utah Legislature passed Senate Bill 148, establishing a statewide collaborative unit of representatives from human service and juvenile justice to coordinate treatment services and establish the continuum of care. In 1994, NOJOS published the *Standards and Protocols for Treatment and Placement of Juvenile Sex Offenders* (NOJOS, 1994). These protocols discussed the client profile, assessment, treatment goals, treatment modalities and frequency, monitoring, and criteria for discharge for each of the eight levels.

Level Six offenders, the population of this research, are seen as imposing sufficient risk to the community to require residential treatment, and yet be sufficiently trustworthy to not need a high

security setting. There should be evidence that a candidate for a Level Six program cannot receive adequate supervision (physical control) in a home or foster home setting in order to prevent reoffending. *The Juvenile Sex Offender Specific Protocols and Standards Manual, Second Edition, Standards and Protocols* (NOJOS, 1996, p. 15) describes Level Six offenders as (a)" having displayed predatory or fixated patterns of offending (setting up their victims by bribes, threats, and so forth); (b) sometimes using force or weapons in committing their sex offenses", and (c) "having a propensity to sexually act out with same-aged peers besides their victims" (they also victimize peers).

Efforts to focus public and private agencies towards the promotion of improved treatment practices have resulted in cooperative efforts to improve the treatment practice of juvenile sex offenders in the State of Utah. For example, a 5-year retrospective study of JSOs offending in 1989 was conducted by University of Utah student Lucinda Rasmussen (1995) in cooperation with the Department of Youth Corrections and the Division of Family Services. This study looked at the influence of demographic characteristics, offense data, data pertaining to the subjects' history of prior victimization, clinical intervention data, and juvenile court sanctions on recidivism. The influence of a broad range of variables on recidivism is an important beginning to take preventative steps based on a prediction of which juveniles will reoffend.

Statement of the Problem

Recently, an implementation study of four nonsecure residential treatment facilities was sponsored by the Western Region Division Child and Family Services (1996). This research provided basic information for discussion among clinicians, but did not have the empirical tools or design necessary to advance the research agenda of the Department of Youth Corrections (DYC): To identify specific program elements that decrease recidivism among JSOs. Utah State University, under the direction of Dr. D. Kim Openshaw, was recently chosen by the DYC to assist in the design and tooling of research necessary to identify specific program elements that demonstrate

themselves to be particularly effective in reducing recidivism. The DYC chose Level Six programs as the first focus of research.

The identification of specific program elements involves a two-pronged evaluation effort: (a) outcome research studying the recidivism rates of each Level Six programs and (b) implementation research to measure the extent that the Level Six programs are achieving good practice standards. Outcome and implementation research, when combined with cross tabulations over time or across treatment sites, can help identify elements of Level Six programs that were effective.

Statement of Purpose

The research focused on the implementation portion of the program evaluations. The purpose of the research was twofold: (a) to develop an objective instrument to evaluate Level Six treatment programs for JSOs and (b) to use that instrument to provide empirical data to measure the extent to which the programs are meeting good practice standards as outlined by NOJOS (1996), the National Task Force on Juvenile Sexual Offending (1993), the Department of Human Services Contract, Medicaid (Department of Family Services/Division of Youth Corrections, July, 1995), and the research literature in general. Six areas were examined:

1. Target population--Does the program provide services for juveniles who present severe risk to reoffend within the community?
2. Intake criteria and process--Does the intake process meet contractual and good practice expectations?
3. Treatment constellation--Does the program provide intensive JSO clinical intervention services?
4. Supervision--Does the program provide intensive JSO supervision within the community and within the program itself?
5. Aftercare--What is the quality of the program's aftercare services?

6. Staff qualifications and training--Do staff members have the training and credentials set forth as guidelines by National Task Force on Juvenile Sexual Offending (1993) and NOJOS (1996)?

The results of this study will be used by DYC for: (a) the assessment of areas that need greater attention, in terms of funding and management and (b) the determination of specific program elements that lead to lower recidivism. Information from this study will be presented to the Utah State Legislature for program funding consideration.

Definitions and Acronyms

Many of the words and acronyms used in this study are relatively unique in the fields of program evaluation and juvenile sex offending. For the convenience of the reader, these words and acronyms with their definitions are listed below.

Accountability: The object of implementation research is to determine the extent to which a program is accountable--or performs according to the wishes and expectations of those to whom the program is responsible. There are two types of accountability. Coverage accountability, according to Rossi and Freeman (1985), examines the following questions: Are the persons served those who are designated as targets? Are there beneficiaries who should not be served? Service delivery accountability, according to Rossi and Freeman (1985), asks these questions: Are proper amounts of outputs being delivered? Are the treatments delivered those that the program is supposed to be delivering?

Clinical intervention: Intervention directed toward the cessation of the sexual assault cycle of the perpetrator (Utah Governor's Council, 1990).

DCFS: The Division of Child and Family Services. An organization with the Department of Human Services in the State of Utah. The acronym DCFS first came into usage in 1996, when the directors of Human Services decided it was important to consider the child before the family.

Hence, the name was changed from the Division of Family Services to the Division of Child and Family Services.

DFS: Division of Family Services. An organization within the Department of Human Services in the State of Utah. The acronym, DFS, was replaced by DCFS in 1996.

DYC: The Division of Youth Corrections. An organization within the Department of Human Services in the State of Utah.

Evaluand: The subject (program or person) being evaluated.

JSO: Juvenile Sex Offender. A youth, ages 10 through 18, who has committed a sex crime as defined by the laws of his or her state.

NOJOS: Utah Network on Juveniles Offending Sexually. A statewide mulidisciplinary network of professionals working with juvenile sex offenders dedicated to organizing knowledge about juvenile sex offenders and promoting effective treatment and supervision.

Nonjudicial closure: A contract with the offender and his or her family for services to include treatment without judicial involvement.

Outputs: The products and services that are delivered to the beneficiary (Rossi & Freeman, 1985).

Petition: A court document detailing the grounds for jurisdiction in the case.

Program Evaluation: The systematic application of social research procedures in assessing the conceptualization and design, implementation, and utility of social intervention programs (Rossi & Freeman, 1985).

Relapse Prevention Model: A major treatment model that asserts that sexual offenses are rarely impulsive acts. Precursors to the act exist. The goal in relapse prevention is to identify the precursors and signs forewarning a relapse and intervene before it occurs (Ward & Hudson, 1996).

SUD: Seemingly unimportant decision. An assumption of the relapse prevention model is that one can covertly set up a lapse, or relapse, by making a series of seemingly unimportant decisions (SUDs).

Sexual assault cycle: A hypothetical perpetual entrapment as low self-esteem leads to dysfunctional thinking and the act of perpetration, and perpetration leads to low self-esteem (Lane, 1991).

Supervision: The physical control of the perpetrator.

Treatment: A court disposition or sentence providing community protection that addresses both supervision and clinical intervention (Utah Governor's Council, 1990, p. 2).

CHAPTER 2

REVIEW OF LITERATURE

This study examines program implementation within nonsecure residential treatment centers for JSOs. This task requires a knowledge of three distinct areas: (a) implementation research techniques, (b) juvenile justice, and (c) JSO specific clinical evaluation and treatment. The literature review will examine each of these areas as they pertain to the treatment programs (Level Six) to be evaluated.

Implementation Research

Implementation research is an activity in program evaluation. The activity of implementation research is sometimes called "process evaluation," though there has been some overlap with the term "formative evaluation" (Dehar, Casswell, & Duignan ,1993; Scheirer, 1994). Formative evaluation differs from implementation research in scope and purpose. Scheirer posited that the purpose of formative evaluation is to obtain data on pilot situations and recipients and assess the feasibility of a program and its fit with the intended recipients. Dehar, et al. specified that formative evaluation requires the evaluator to work closely with program personnel involved in decisions about the planning, development, and implementation of the program. Because this research does not involve working with decision makers in the planning and development of the programs, the term "implementation" rather than "formative" research will be used.

The History of Implementation Research

Evaluation research had its origins in the field of education and testing that began in the United States in the early 1900s (Worthen & Saunders, 1987). It was not until the late 1960s, however, that evaluation became a field or profession (Campbell, 1994). As a field, it became known as "program evaluation." Program evaluation, once the exclusive domain of education, has

become invaluable to the research arsenals in psychology, sociology, health sciences, criminal justice, and family welfare (Smith, 1994).

Program evaluation, from the very beginning, was faced with an identity crisis. Campbell (1969), in what has been called the "most influential work in the field of program evaluation" by Rossi and Freeman (1985), espoused a positivistic paradigm. In contrast, Cronbach (1982) saw program evaluation as a constructivistic activity focused on being useful to decision makers, given the resources, political circumstances, and program constraints surrounding them. The positivistic versus constructivistic debate continues today (Campbell, 1994; Sechrest & Figueredo, 1993; Smith, 1994).

The phenomenological debate between positivists and constructivists continues to have evaluators questioning whether they should focus exclusively on outcomes (Campbell, 1994; Sechrest, 1994), or involve themselves in wider arenas, such as program implementation (Chen, 1994). For example, Newcomer, Hatry, and Wholey (1994) emphasized the systematic assessment of program results and the extent to which the program caused those results as the major activities of program evaluation. Rossi and Freeman (1985), in juxtaposition, emphasized the activities of assessing the conceptualization and design, implementation, and utility of social intervention programs as the major activities of program evaluation.

The argument for maintaining an exclusive focus on outcomes has at times been heated. Sechrest (1994) posited that program evaluators became interested in implementation research because (a) outcome research demanded too much rigor of them and (b) adequate research designs to measure program outcomes did not exist; therefore program evaluators avoided the "difficult task" of designing those programs and focused on implementation. Sechrest (1994) agreed that broadening the focus of program evaluation to include implementation occurred because program evaluators found outcome research too difficult. Sechrest presented a metaphor depicting his negative views of the contribution of evaluating implementation:

> The result will be that we learn how to improve programs that may be doing no good at all. Does providing more and franker sex education and distribution of condoms to teenagers increase or decrease sexual activity and risk of pregnancy and sexually transmitted diseases? . . .So why not just concentrate on how to increase the number of teenagers involved in such programs, increase the number who carry condoms, and so on? (p.362)

The argument espousing a broader focus of evaluative research to include implementation research is also intense. Weiss (1993) proposed that the exclusive focus on outcomes limited the impact evaluators had improving social programs during "The Great Society" and "The War on Poverty." Weiss (1993) further posited that "widening the purview" of evaluation has strengthened the influence of evaluation research on political decision making. Chen (1994) lauded program implementation research as helpful in providing timely information in locating any potential problems in program processes in time for improvement. Rossi and Freeman (1985) argued that implementation research facilitated efficiency in the management and administration of human resource programs and provided evidence to program sponsors and stakeholders that what was requested and paid for actually was delivered. Implementation research of sex offender programming is a critical component of public accountability (Smith, 1995). Dehar et al., (1993) pointed out that without program implementation research, it is impossible to judge whether a program's failure to show impact is due to the program design or the failure of the program to implement the program as originally specified. Further, without implementation research, it is difficult to retrieve the detailed information needed to replicate a program's successful impact. The information gleaned from program implementation research is a powerful tool for program managers in documenting the operational effectiveness of their program, justifying the administrative procedures, and requesting further program support (Rossi & Freeman, 1985). Program implementation research is a natural precursor to impact evaluation (Scheirer, 1994). Implementation data provide a fertile foundation from which correlational or cross tabs researchers

can examine the extent of impact as it relates to changes over time and among various delivery sites (Scheirer, 1994). Such information will lead to more effective treatments and lower recidivism rates (Green, 1995). It can guide policy makers in decisions pertaining to those individuals entering limited-space treatment facilities or those returning to the community. Smith (1995) noted:

> It makes little sense to conduct outcome evaluations or make attributions to programs that fail to implement program goals because they are chaotic, poorly staffed, fail to provide educational or therapeutic interventions of sufficient length or intensity, and so forth (p. 7-11)

In summary, implementation research has been noted in the literature to make several contributions to program evaluation, including: (a) it has strengthened program evaluation's ability to influence political decision making; (b) it helps managers locate potential problems in a timely fashion; (c) it provides evidence that the program desired was the program delivered; (d) it allows managers to determine if a program's failure was due to design or failure to implement; (e) it provides the detailed information needed to replicate a successful program; (f) it provides a tool for managers to document program effectiveness, in justifying administrative procedures and requesting further program support; (g) it provides a statistical foundation from which outcome research can generate treatments that work; and (h) it can help policy makers make better decisions about how to use time-limited treatment facilities (Green, 1995).

Methods in Implementation Research

The first step in conducting implementation research is to clarify the evaluation mandate. It is important to get a clear conception of the sponsor's expectations and needs. Evaluators must be in touch with the realities of the program they are evaluating. The agreement reached on the evaluation mandate should be checked periodically during contacts with evaluation clients and sponsors. Policy makers need to see evidence that (a) the evaluator understood the program; (b) the evaluation is based on appropriate data; (c) the recommendations are clear about why and how

to modify the program; and (d) the evaluators understand what is likely to happen if the recommended changes are made (Bell, 1994).

After the mandate is mutually understood and agreed upon, the design work begins. The evaluator should select the sample and sampling techniques, how the data are to be collected and analyzed. These methods should be shared with the sponsor. If possible, an initial outline of the report also should be shared with the sponsor.

The full gamut of statistical techniques is available to the researcher doing implementation studies (Scheirer, 1994). Scheirer has recommended methods such as use of technical equipment, indirect unobtrusive measure, direct observation, activity or participation logs, organizational records, written questionnaires, telephone or in-person interviews, and case studies. Each method of analysis has different strengths and weaknesses, and the researcher should be prepared to deal with the challenges presented by the weaknesses.

An example will serve to demonstrate the numerous methods that can be employed to analyze implementation data, and how the creative use of numerous methods can resolve problems. Berecochea and Gibbs (1991) performed an implementation study of California's prison inmate classification system. The goal of the study was to ascertain if a new classification system would reduce the rate of serious prisoner misconduct by correctly classifying prisoners on the levels of needed intervention. The study used management information system data collected retrospectively on over 14,000 prisoners. The data were analyzed using multiple logistic regression and time series analysis. The researchers found that the new classification system was effective in reducing the rate of increase in the incidence of serious prisoner misconduct. However, ex post facto research and multiple regression analysis were inadequate to give predictive validity to the scale items. To deal with the need for predictive validity, the researchers used a natural experiment to see if departmental experience could be used as an effective tool to reduce overclassification. The results demonstrated that departmental experience could be used to predict which higher security prisoners could function well in a lower security setting.

Specifying the program components--including activities, strategies, behavior, written and media materials, and technologies needed to deliver the program, along with a specification of the intended recipients and delivery situations (Scheirer, 1994)--is another initial step in implementation research. The specification of the program components is a detailed and often time-intensive process. This process can involve such methods as extensive interviews, review of program materials, focus groups, or observation (Lipps & Grant, 1990; Scheirer, 1994). It can also draw from theory or formative evaluation (Scheirer, 1994). After specifying the program components, the researcher and client determine which components will be included in the research. It is important to do this step after the items have been listed so as not to leave out important items. The next step is deciding on operational definitions of the components (Lipps & Grant, 1990). Activities must be specified as a behavior that can be observed, rather than as goals or objectives (Scheirer, 1994). Further, the components must be sorted to exclude duplicates (Lipps & Grant, 1990). For example, often the performance of one activity depends upon another activity being performed. In such a case, the initial activity should be excluded as the performance of the latter activity was dependent upon the performance of the initial activity. With the list of components and operational definitions, the researcher determines the evaluative questions and how these questions will be measured (Worthen & Saunders, 1987). The researcher will need to anticipate what resources are needed to measure the evaluative question, and what will indicate implementation. The researcher needs to understand the form and detail in which the data are available. Further, the researcher needs to determine who will measure the evaluative questions. Often, in implementation research, more than one instrument or more than one part of the instrument may require more than one evaluator.

Once the instrument(s) is created, a pilot test of the instrument should be conducted. Observations gleaned from the pilot study, as well as suggestions from the evaluand and the sponsor, can be incorporated to refine the instrument to make it more useful and methodologically sound.

Participants should be trained prior to the actual fieldwork. They need to know the objectives, the procedures, the schedule of interviews, and the confidentiality policy. Housekeeping details such as confirmation of the date of the site visit, the records and other materials that should be made available, the names or positions of persons who will be evaluated, and so forth, must be carefully attended to.

The fieldwork is the data collecting part of the research. If the interview is verbal, interviewers should be familiar with the content and purpose of each question. Each interview should begin with a short introduction of the evaluator's purpose and an assurance of confidentiality. When the fieldwork is finished at the site, evaluators should not report on findings. Rather, such briefings should occur only after all the data are in and have been analyzed (Nightingale & Rossman, 1994).

The final step in an implementation research project is the final report. The researchers should have an agreement with the sponsor about the content of the report through outlines and briefings before extensive effort is spent writing the report. The essence of the report should be summarized for the sponsor before it is actually written (Bell, 1994). A briefing package can be constructed presenting the project results as early as possible in preliminary form. A complete draft report should be written focusing on the technical content. Editing and polishing the document should not be done until the technical contents of the final report are reviewed and confirmed by the sponsor, subject program staff, and any outside experts included in the project as advisors. The final step is writing the report in a manner that will be easily understood by the intended audience.

Implementation research is a systematic process aimed at ascertaining the degree to which a program meets the processes or goals it ascribes to meet. Table 2.1 summarizes the steps in conducting implementation research.

Methodological Problems in Implementation Studies

Implementation research on JSO programs is challenged by at least three parameters: (a)

Table 2.1

Methods in Implementation Research

Step	Activities
Clarify evaluation mandate	Clarify the expectations of sponsor and evaluator concerning the evaluation results.
	Obtain a shared understanding of steps in the project management.
	Check the evaluation during evaluation (i.e., when discussing data with sponsor).
Design evaluation	Select the sample (s).
	Decide how the data will be collected.
	Decide how the data will be analyzed.
Create instrumentation	Specify and operationalize the components.
	Decide which components to include in the the instrument.
	Determine how evaluative questions will be measured.
	Determine who will measure evaluative questions.
Do pilot study on instrument	Test instrument on one program.
Refine instrument and design	Use suggestions from evaluand and sponsor and observations of evaluator to increase usefulness and methodological rigor.
Train participants	Brief program to be evaluated and sponsor on procedures.
	Clear up housekeeping items such as date of visit, records and other data sources that should be available, who is to be interviewed, and so forth
	Discuss objectives, schedule interviewers will follow, and confidentiality procedure.
Conduct Fieldwork	Inform Interviewers of content and purpose of questions before interviewing.
	Collect data .
	Start each interview with introduction and assurance of confidentiality.
	Do not attempt to draw conclusions in the field.
Analyze	Summarize information systematically.
	Use any type of statistical technique.

(table continues)

Step	Activities
Report	Show sponsor preliminary results as soon as possible.
	Have sponsor check draft for technical quality.
	Focus report on needs of intended audience(s).
	Offer only realistic recommendations.
	Show future implications of recommendations.
	Make recommendations easy to understand.

sex offending realities, (b) juvenile justice practices, and (c) health care practices. It is not possible to construct the perfect methodological research given these constraints. However, much can be done.

Need for operational definitions. The need for operational definitions was recognized by Becker and Abel (1983) in their work with the first nationally recognized JSO program (The JSO Program at the University of Washington). Normative exploratory behavior must be distinguished from deviancy, and any labels attached to the offenses, such as "assault," "rape," and "pedophilia," should be defined explicitly to avoid overlap across diagnoses.

Need to include input from practitioners. The need to include the input of practitioners in constructing implementation research that influences the policy of social services was recognized by Unrau (1993). Too often, social service evaluations focus exclusively on accountability and economy. Evaluations focused on accountability aim to assess the effectiveness of program intervention for the targeted social problem in accordance with the values supported by the policy. Evaluations focused on economy aim to produce the most favorable results to justify continued and usually increased funding. Practitioners are in a position to educate evaluators about client values and needs.

The inclusion or exclusion of practitioners in constructing implementation research in community-based programs (such as the Level Six JSO treatment programs) will be determined largely by the sponsoring or funding agency, as described by Leviton (1994). According to Leviton (1994), any program described as "community-based" can be understood to be sponsored professionally, by the community, or by a combination of both. In research of community-based programs sponsored both professionally and by the community (such as NOJOS), it is common to use a negotiation process to set evaluative questions that are compatible with an overall program theory, but also with the community's needs for information.

Need for validity and reliability. The lack of concern for validity and reliability is a major problem noted in conducting evaluation research in the juvenile justice system (Henggeler, Smith, & Schoenwald, 1993) and health care practices (Silverman, Ricci, & Gunter (1990). Henggeler et al. pointed out that too often, a theoretical rationale is missing in the construction of juvenile offender--including JSO treatment. Silverman et al. discussed the methods they used to increase the validity and reliability of their research, including: (a) the use of a multidisciplinary research teams, (b) selection and training of field researchers, and (c) targeted interviews permitting collection of information from the most knowledgeable respondents.

Summary. Methodological concerns are as important in implementation research as other empirical research. In summary, three points have been made regarding implementation research relevant to methodological dimensions of JSO research: (a) use operational definitions, (b) include the input of practitioners, and (c) protect the validity and reliability of the data as much as possible.

Juvenile Justice

The juvenile justice system must react to sex offenses committed by juveniles in a way that not only protects the community and holds the victim accountable, but also recognizes that the youth must gain the ability to live productively and responsibly in the community (Bala & Schwartz, 1993). Since the inception of the first juvenile courts around the turn of the century, juvenile officials

have struggled with the issue of accountability versus rehabilitation (Guarino-Chezzi & Loughran, 1996).

During the first 50 years of the juvenile justice system (around 1910-1960), the mission of juvenile justice systems was clearly focused on rehabilitation and treatment (Guarino-Chezzi, & Loughram, 1996). Early juvenile courts were informal and had the express purpose of protecting children. Due process protections and attorneys for the state and the youth were not considered necessary (Thomas, 1992). The early days of the juvenile justice system shaped many of the principles currently valued in work with juvenile offenders (Guarino-Chezzi & Loughram, 1996), specifically,

1. The notion of the state as protector of juveniles shaped the early philosophy of separate treatment of juvenile offenders in juvenile courts and correctional placements

2. In juvenile court, there are "hearings" rather than trials, youth are "adjudicated delinquent" rather than found guilty of a particular offense, and the dispositions or sentencing options are, in theory, more reforming than are those for adults (Guarino-Chezzi & Loughram, 1996).

The focus on rehabilitation was supplanted by a more conservative approach in the last half of the century as society became increasingly aware of community safety and victim concerns (Guarino-Chezzi & Lougrahm, 1996). This more conservative view gave due process rights to juveniles, and made juvenile court proceedings more like adult court proceedings. It also sent more juveniles to institutions, as law makers were under political pressure to "get tough" on juvenile crime.

Juvenile Justice and Juvenile Sex Offending In Utah

The State of Utah seeks to achieve a balance between the need for accountability and contrast to the majority of states that favor either a punishment or rehabilitative mode (Thomas,

1992). community protection and the offender's need for treatment in its disposition of JSOs. This is in JSO treatment, as defined by Utah's "Comprehensive Plan For Juvenile Offenders" (Utah Governor's Council, 1990, p. 2), is "a court disposition or sentence providing community protection that addresses two major components: (a) supervision (the physical control of the perpetrator) and (b) clinical intervention (cessation of the sexual assault cycle of the perpetrator)." Supervision levels have been envisioned as a continuum of care and services such that an offender at a higher level will work his or her way down to the lowest level before supervision and treatment are terminated. Low supervision includes monitoring of treatment and minimal observation; medium supervision includes probation or protective supervision; and high or extreme supervision includes the possibility of placement in specialized foster care, structured or group home, residential treatment center, the state hospital, or a secure facility (Gerdes et al., 1995). The "sexual assault cycle" (Lane, 1991) refers to a hypothetical perpetual entrapment as low self-esteem leads to dysfunctional thinking and the act of perpetration, and perpetration leads to low self-esteem. The rendering of the court disposition follows a process involving the combined expertise of child protection workers, police officers, sex-specific assessors, probation officers, and the judge.

When an officer encounters a juvenile in Utah who has been accused of committing a sex offense, the officer, usually in conjunction with Child Protective Services (CPS), makes a decision as to whether or not to refer the case to juvenile court. An initial assessment (termed "Level A: Line Worker Assessment") is required of all juveniles referred to juvenile court or CPS (NOJOS, 1996). The CPS worker making the Level A assessment reviews the police report (if not involved in a joint investigation) and considers the statements of the victim, witnesses, parents, and the juvenile. The CPS worker and officer determine whether or not there is probable cause, based on the evidence, for a referral to juvenile court (NOJOS, 1989).

If probable cause is determined to exist, the CPS worker refers the case to court, where a court intake worker examines the evidence. The court intake worker then has three options: (a) close the case if there is insufficient evidence; (b) "nonjudicial closure" or contract with the offender

and his or her family for services to include treatment without judicial involvement; or (c) petition the court for adjudication. The nonjudicial closure is an option in a misdemeanor sex offense in which the offender readily takes responsibility for his or her behavior and the parents are cooperative with treatment. The condition of nonjudicial closure is that the offenders and parents follow specific requirements, which almost always include involvement in outpatient sex offender specific treatment (NOJOS, 1989). A petition usually will be requested whenever the alleged offender denies committing the offense, or when the offense appears to be more than an isolated, exploratory incident (NOJOS, 1996). A petition is a court document detailing the grounds for jurisdiction in the case.

Petitioned cases are given formal arraignments, at which the youth is read the charges and given an opportunity to admit or deny the allegations. If a youth denies the allegation, a pretrial is set, during which attempts are made to resolve the case without a trial. If the case is not settled in pretrial, a formal trial occurs in which formal evidence is presented and the judge determines the guilt or innocence of the accused. If there is insufficient evidence at the trial, the youth is found not guilty and the case is closed. If, however, the youth admits the offense at either the arraignment or the pretrial, or is found guilty at the trial, a disposition is ordered.

In determining the disposition, the intake officer constructs a recommendation based on all of the information presented, including psychological evaluations, the CPS investigation and police reports, and if the offender has already entered treatment, reports of progress from the therapist. The judge then approves, revises, or rejects the recommended treatment plan and determines the consequences for the offense. These consequences most frequently determine the initial level of treatment/placement for the youth (Appendix A). Additionally, the court may impose other sanctions such as no contact with the victim, prohibition against babysitting, payment of restitution to the victim for counseling costs, and assessment of fines and/or community service work hours.

Utah is prominent in the national effort to improve the quality of the court's response to JSOs (Thomas, 1992). Utah's efforts to provide a balanced approach to juvenile sex offending reflect the optimal state planning efforts specified by Knopp (1985, p. 33-34):

1. The development of a capacity for training specialists in the public and private sectors to assess, evaluate, and treat JSOs;

2. The development of a specialized capability to assess all JSOs prior to adjudication so that recommendations for appropriate placement and treatment can be offered to the court before sentencing occurs;

3. The provision of fiscal and staff support for networking among treatment providers, victim-service specialists, and related criminal justice personnel;

4. The establishment of residential, therapeutic communities for the serious adolescent sex offender, either in the private or public sector, with special provisions for those few who require more secure treatment settings;

5. The inclusion of a research component that standardizes the collection of data, establishes offense typologies, and measures treatment outcomes; and

6. The Identification and selection of the proper placement from a range of treatment settings, including community-based, nonresidential through secure residential, followed by posttreatment follow-up and aftercare.

Conclusion

The juvenile justice system emerged around the turn of the century in an effort to protect youth from the harshness of the adult criminal system. Two major problems were evident in how the system functioned during the first half century. First, the public was dissatisfied that they were not being adequately protected from crimes committed by young people. Second, young people did not have constitutional rights, including the right to be represented by an attorney. During the second half of the century, both of these issues have been addressed. Today, most states favor either a rehabilitative or punitive strategy for juvenile offenders. Utah, however, seeks to achieve

balance. For juvenile sex offenders, Utah has set in place a variety of services that individualizes treatment according to need.

The Treatment of Juvenile Sex Offenders

Sex abuse is a progressive and contagious social illness. There is a link connecting victims of sexual abuse to sexually reactive children, preadolescent and adolescent sex offenders, and adult sex offenders (Rubinstein, Yeager, Goodstein, & Lewis, 1993; Thomas, 1992; Utah Governor's Council, 1990). The treatment of sex offending is thus a holistic concern (Utah Governor's Council, 1990); and the treatment of JSOs is an attempt to arrest the contagion before it becomes unmanageable.

As a social illness, sexual abuse spreads germs of criminality into the community. Many (about 40%) juvenile offenders are themselves victims of sexual abuse (Ryan, Miyoshi, Metzner, Krugman, & Fryer, 1996), recapitulating their sexual trauma upon other victims (Prentky & Burgess, 1991). The contagion spreads to an average of eight other victims, according to a large national database (Ryan et al., 1996). Juvenile sex offenses are often preceded and followed by an extensive history of nonsexual criminality. Nearly 50% of the Kahn and Chambers (1991) subjects offended nonsexually during a 20-month follow-up period. Rubinstein et al. (1993) studied 19 JSOs and 58 juvenile nonsexual offenders for 8 years following treatment. After obtaining information regarding adult criminality from police and FBI records, the researchers found that 37% of the sexually assaultive juveniles and 10% of the control group had adult criminal records of one or more first- or second-degree sexual assaults. Eighty-nine percent of the sexually assaultive juveniles, compared with 69% of the comparison group, had been arrested for nonsexual offenses.

Sexual abuse that is perpetrated by juveniles tends to be more violent than sexual abuse perpetrated by adults, and has similar negative psychologic sequella (Elliot & Smiljanich, 1994). Short-term effects include emotional disturbances such as feelings of anxiety and fear, sleep and eating disturbances, anger and hostility, behavioral and social problems, and early marriage

(Barbaree et al., 1993). Long-term disturbances include psychopathology, lowered self-esteem and negative self-concept, disturbances in social interaction and affiliation, difficulties with intimate relationships and sexual adjustment, and serious problems trusting others (Barbaree et al.).

Many researchers today are convinced that early intervention is the best method of arresting the spread of sexual abuse in society (Becker, 1994; Graves, 1993). First, the treatment of JSOs may prevent multiple victims in the future. Though juvenile offenders report having seven or eight victims each, adult offenders report having dozens of victims (National Task Force on Juvenile Sexual Offending, 1993; Ryan et al., 1996). Additionally, early intervention may arrest the development of more complex patterns of sexually offending behavior. Many adults report less complex paraphilias and sexually offending behavior patterns as adolescents (Able, Osborne, & Twigg, 1993; Becker, 1994). Finally, the treatment of JSOs may remediate some of the developmental circumstances related to the sexual abuse. It seems reasonably clear that sexual abusive behavior is an outcome of a long trail of unhealthy biological, psychological, social, and familial events and experiences (Becker, Kaplan, Cunningham-Rathner, & Kavoussi, 1986; Graves, 1993; Saunders & Awad, 1988). Treatment during adolescence may arrest and remediate some of the psychosocial damage imposed by traumatizing circumstances (Heinz, Gargaro, & Kelly, 1987).

Treatment programs for JSOs have sprung up quickly in response to the recent awareness of the scope of the problem (Freeman-Longo et al., 1994). To determine the efficacy of programs in curtailing juvenile sex offending, it is important to identify what the program is. Freeman-Longo et al. surveyed the treatment strategies and orientations of almost 700 treatment programs for JSOs nationwide. A more detailed analysis, however, is required of specific programs.

Programs for JSOs rely on federal, state, and local resources for economic support. The need for financial support is a political reality that makes a difference in programming (Sapp & Vaughn, 1990). Programs for JSOs must therefore be highly accountable to federal, state, and local money sources. The proposed implementation research attempts to measure two types of accountability. First, coverage accountability will be examined. Coverage accountability, according

to Rossi and Freeman (1985), examines the following questions: Are the persons served those who are designated as targets? Are there beneficiaries who should not be served? The second type of accountability to be examined is service delivery accountability, asking these questions: Are proper amounts of outputs being delivered? Are the treatments delivered those that the program is supposed to be delivering? Outputs are defined as the products and services that are delivered to the beneficiary (Rossi & Freeman, 1985). The beneficiary can be society--through which the sponsor obtains a lower frequency of sex offenses--or the client, who, as a result of treatment, can achieve a healthier lifestyle.

Literature pertinent to the determination of coverage accountability will be examined first. Who does NOJOS say should be in a Level Six program and why? Are there different opinions in the literature regarding who best qualifies for a nonsecure residential placement?

The literature will then be examined regarding service delivery accountability to determine the outputs to be expected of a Level Six program. Service delivery accountability includes the target areas of intake criteria and procedure, treatment constellation, supervision, aftercare, and staff qualifications and training. In some of these areas, guidelines have been provided by NOJOS (1996) or the National Task Force on Juvenile Sexual Offending (1993), or the Department of Human Services, State of Utah Contract. These guidelines are usually based on careful attention to models and good practices espoused by the literature. A review of the literature on models and good practices, along with the guidelines provided by NOJOS and the Department of Human Services (DHS), State of Utah Contract, will be summarized to ascertain expectations regarding service delivery accountability.

Coverage Accountability

Coverage accountability, according to Rossi and Freeman (1985), examines the following questions: Are the persons served those who are designated as targets? Are there beneficiaries who should not be served? The placement of a youth in a residential facility represents a decision that one or both of the following are true: (a) the offender represents a serious risk to community

safety if not supervised 24 hr a day; or (b) the offender needs intensive treatment that cannot be achieved on an outpatient level (see Table 2.2; NOJOS, 1996). An additional consideration is a increased correctional staff ostensibly costs much more than a community-based outpatient matter of practicality: Less expensive and less intensive placements are not available in some communities of Utah (Western Region DCFS, 1996).

Both financial and safety consequences may result from overclassifing a JSO into a Level Six program. In terms of economy, a secure treatment unit with lock down physical facility and treatment facility. Public safety may also be compromised by overclassification. Rasmussen (1995) performed a 5-year retrospective study on a large and inclusive database of juveniles sexually offending in Utah in 1989. Youth who were released from residential programs tended to reoffend nonsexually less but reoffend sexually more than youth who were treated in the community.

Assessing Level of Risk/Need

Although maintaining community safety is the highest priority (Barbaree & Cortoni, 1993; National Task Force on Juvenile Sexual Offending, 1993) in making treatment/placement decisions, current taxonomies of risk factors are based on clinical experience rather than empirical study. I could find only two constellations of risk factors identified in the literature (Knopp, 1982; Perry & Orchard, 1992). These constellations identify risk factors pertinent to offenders who should be placed in residential treatment, but do not distinguish between those who should be in secure versus nonsecure treatment.

Knopp's (1982) report on a historical, early national workshop on JSOs contains a checklist of risk factors based on the clinical experience of Wenet and Clark, two of the earliest sex offender-specific therapists. Knopp reports that Wenet and Clark considered any offender who used a weapon or force as needing residential treatment. Perry and Orchard (1992) divided risk characteristics into high and low risk factors. Perry and Orchard pointed out that youth committing

Table 2.2

The NOJOS (1996) Typology of JSOs

Level	Characteristics
One	Younger adolescents
	No previous reported history of sexual acting out
	Sexual incidents are isolated, exploratory, and situational in nature
	No use of coercion or violence
Two	Little or no history of prior sexual acting out behavior
	More extensive patterns of sexual behavior (e.g., greater number of offenses and victims when compared to Level One) with younger children
Three	Some patterned and repetitious sexual offenses
	May have similar sexual patterns as in Level Two, but exhibit more extensive behavioral and emotional problems
Four	More serious than Level Three
	Adolescents who have displayed predatory patterns of offending, used force or weapons in committing their offenses, shown propensity to act out with same-aged peers, and/or displayed acute or chronic psychiatric disturbance
Five	Adolescent who presents a significant concern to the community, of whom very little information is known
Six	Patterned, repetitious sexual offenses and acting out behavior
	May have displayed: (a) predatory or fixated patterns of offending, (b) use of force or weapons in committing their sex offenses, and/or (c) a propensity to sexually act out with same-aged peers besides their victims
	May also be appropriate for adolescents with extensive behavioral and emotional problems
Seven	Mentally ill offenders demonstrating psychotic processes, self-destructive behavior, and/or severe aggression
	Offenses may be a single, unpredictable, uncharacteristic act or patterns of bizarre and/or ritualistic acts
Eight	Typically have an average of 8 felonies and 18 misdemeanors
	Sexual offenses are patterned and repetitious
	Have displayed predatory or fixated patterns of offending, use of force or weapons in their offenses, and/or a propensity to sexually act out with same-aged peers besides their victims

any of the following offenses requires residential treatment: (a) The offender acknowledges his or her offense but is violent; (b) the offender has offended against multiple victims; (c) the offender has shown disregard for victims' distress; (d) the offender demonstrated an escalation in the frequency of offenses or in the type and level of aggression;(e) the offender is highly delinquent; (f) the offender has received community-based treatment but has continued to offend; (f) the offender has no family or community support network (e.g., has a family that is very dysfunctional and/or is unsupportive of treatment). A risk factor constellation based on the combined list of Wenet and Clark's and Perry and Orchard observations is found in Table 2.3.

The Western Region DCFS (1996) constructed an inventory to measure Level Six implementation. This instrument utilized the criteria from NOJOS (1994). Risk was defined as "predatory, violent, entrenched in sexual offending pattern. . . patterned repetitious sexual offenses and acting out behaviors and/or have used force or weapons in committing their offenses. . . propensity to act out with same-age peers besides their victims" (p. 15).
Need was defined as having a "prior history of sex offending treatment. . . extensive behavioral and emotional problems. . . cannot receive adequate supervision and treatment in group or foster sex offender specific enriched homes" (p. 15).

Verifying Risk/Need

The Western Region DCFS (1996) addressed the issue of how risk and need were to be determined by the State of Utah when placing a youth in a Level Six program. The stipulations of the Western Region are not mandates, but rather a means of measuring how a Level Six program's practices match practice procedures gleaned by the Western Region from NOJOS (1996) and other literature. The Western Region gives three guidelines.

1. The youth should have a Level A assessment (NOJOS, 1996). This evaluation is performed by the CPS worker during the initial investigation. A Level A assessment establishes an initial risk level, based on the current offense circumstances, sex offending history, quality of

Table 2.3

Risk Factor Constellations

Level of risk	Wenet and Clark	Perry and Orchard
Higher risk	Uses weapon, force, or threats	Uses weapon, force, or threats
	Uses denial, minimization and projection regarding offense	Resists taking responsibility for offense
	Commits more than one offense	Commits multiple assaults on more than one victim
	Is socially isolated	Is socially isolated
	Has negative family relations	Has family dysfunction
	Resists discussing offense	Has trouble discussing offense
	Resists participation in evaluation	Selects victims varying in age, gender and relationship
	Continues to offend in spite of victim protest	Escalates sexual offending pattern in terms of frequency or duration or intensity
	Reoffends after treatment	Has history of delinquency
Lower risk	Has no previously documented offenses	Is passive and manipulative
	Has a family who is supportive of treatment	Has no previous treatment for sexual offending
	Is willing to discuss offense	Does not blame victim for assault
	Expresses empathy for victim	
	Understood what society regards as wrong about offense	

custodian's supervision of the juvenile, and the juvenile's attitude toward supervision and clinical intervention. The higher the number of points given during a Level A assessment, the greater the presumed risk. The highest number of points goes to one factor, "prior sex offender specific clinical intervention." Similarly, a high number of points is assigned to factors such as "juvenile denies or minimizes offense," "custodian denies or minimizes offense," "custodian can not or will not facilitate clinical intervention," "custodian can not or will not provide protection for victims," "custodian can not

or will not cooperate with authorities." A Level A assessment is adequate for the first two levels of placement/supervision.

2. Offenders referred to Level Six placement also should have either a Level B or a Level C assessment (NOJOS, 1996). A Level B assessment is conducted by a clinician with specialized expertise in assessing JSOs. This level of assessment consists primarily of accepted psychosocial and psychosexual screening techniques. Level C sex offender-specific assessments are required for Levels Five through Eight. A Level C assessment includes the psychosocial and psychosexual components of the Level B assessment, in addition to a psychological and psychiatric evaluation.

3. The youth's case should be staffed by professionals with JSO specific training and qualifications per professional discipline. Professional qualifications for sex offender specialists (NOJOS, 1996) include 2,000 hr of experience working with JSOs and 50 hr of supervision.

Summary

Characteristics have been determined by clinical experience to require that a JSO enter a residential program. First, NOJOS specified that youth with the following characteristics should be placed in Level Six programs:

1. The youth has patterned, repetitious sexual offense and acting out behaviors.

2. The youth may have used a predatory pattern of offending. Thomas (1992) defines "predatory" as "setting the victim up."

3. The youth may have used a fixated pattern of offending (done the same kind of offense more than once.)

4. The youth may have used force in committing the offense. Perry and Orchard (1992) defined force as threats, tricks, bribes, or physical coercion.

5. The youth may have used a weapon in committing the offense.

6. The youth may have had nonconsensual sexual contact with same-aged peers besides the victim.

Early juvenile sex offender therapists Wenet and Clark (Knopp, 1982) specified that the disposition of JSOs who use weapons should always be a residential treatment facility. Perry and Orchard (1992) added to the NOJOS list some additional risk factors to include in residential dispositions:

7. The offender acknowledges her or his offense but is violent.

8. The offender has offended against multiple victims.

9. The offender has shown disregard for victims' distress.

10. The offender demonstrated an escalation in the frequency of offenses or in the type and level of aggression.

11. The offender is highly delinquent.

12. The offender has received community-based treatment but has continued to offend.

13. The offender has no family or community support network.

The assessment of need was addressed by the Western Region DCFS (1996). The three factors used in assessing need were:

1. The offender has had a prior history of sex offending treatment.

2. The offender has extensive behavioral and emotional problems.

3. The offender cannot be adequately supervised in less restrictive placements.

As important as it is to define what a Level Six candidate is, it is also important to remember what a Level Six candidate is not. JSOs who have not used coersion (predatory or use of weapon) or have not been involved in nonconsensual sex with same-aged peers or who do not have extensive behavioral or emotional problems do not, according to the NOJOS classification system, require Level Six treatment. JSOs who are mentally ill or have had a record of excessive felonies and misdemeanors, however, require more intensive supervision than Level Six.

Verification of the youth's eligibility for a Level Six placement is achieved through three tools:

1. A NOJOS Level A assessment

2. A NOJOS Level B or C assessment

3. A clinical staffing involving a juvenile sex offender-specific specialist with qualifications per professional discipline.

Service Delivery Accountability

Service delivery accountability concerns such areas as intake criteria and procedure, treatment constellation, supervision, aftercare, and staff qualifications and training. Each of these areas will be reviewed in the following manner. First, the literature suggesting good practice procedures, when available, will be reviewed. Samples of existing residential treatment programs will be reviewed as prototypes. Sample curriculums could be found from three programs: The Hennepin County Home School in Minnetonka, Minnesota (Heinz et al., 1987) ; the Echo Glen Children's Center in Snoqualimie, Washington (Knopp, 1982); and the Gibault School in Terre Haute, Indiana (Thomas, 1992). Second, the guidelines used by the Western Region DCFS (1996) will be reviewed. Finally, the expectations of NOJOS, Medicaid, Office of DHS licensing, and the DHS contract will be presented and linked with the literature.

Intake Criteria and Procedures

Literature on intake criteria and procedures describes assessments, personal criteria, and procedures required to admit a JSO into existing nonsecure residential programs. In general, intake criteria and procedures is heavily influenced by the federal government through Medicaid and the state government by Child Protection and Youth Correctional licensing and contract agreements.

Literature. One of the realities of residential treatment facilities that are non- to moderately secure is that program directors prefer to limit intake to those who will not require excessive discipline or monitoring. At the Hennepin County Home School (Heinz et al., 1987) and the Echo Glen Children's Center (Knopp, 1982), this is not possible, as the referrals are court-controlled. Two of the programs examined preferred to not treat youth who have had problems with delinquency. The Hennepin County Home School (Heinz et al.) cannot reject JSOs with

delinquency problems when referred from their own county court. They do, however, refuse enrollment to noncounty JSOs who have five or more documented incidents of assaultive nonsexual behaviors, and a history of delinquency 1 year prior to the commitment of the sexual offense. The Echo Glen Children's Center (Knopp, 1982) accepts all the children sent there, but assigns the sexually assaultive youth to a different treatment modality. Two of the schools listed IQ cut-off scores of 75 as a criterion for acceptance (Heinz et al., 1987; Thomas, 1992). The Gibault School (Thomas, 1992) requires that boys be able to perform recreational activities. Further, they do not accept boys with severe emotional disturbances and in need of medical supervision. The Gibault School was the only school that accepted only males.

Western Region. The Western Region DCFS (1996) outlines guidelines for preadmission criteria and the intake process. According to the Western Region, the referent should have obtained or performed a Level B or Level C assessment prior to referring the youth to the Level Six program. This requirement is different in a significant way from the requirement for a Level A and a Level B or C assessment mentioned under the auspices of target population. Prior to the intake decision, a Level A and a Level B or C assessment is necessary; however, if proper intake procedure is followed, the referent will submit the assessments with the referral. Additionally, the program should have written intake criteria to include the gender of youth, range of age, DSMIV diagnostic categories that the program is not designed to address, profiles of youth, level of risk to community ad other clients, cognitive capabilities of youth, level of parental and/or community support required, judicial and legal requirements, other criminal or antisocial behaviors that do not preclude admission such as fire setting, assault, and so forth. In outlining the intake process, the Western Region posits that the program should (a) have a designated intake coordinator; (b) conduct a sex offender specific intake assessment, which includes a juvenile sex offender specific intake form and interview; (c) provide the contract monitor and caseworker the specific reasons for not accepting a youth, along with recommendations for alternative placements; and (d) provide the youth and parents/guardians with written copies of the program procedures and goals.

NOJOS. NOJOS (1994, 1996) serves as the basis of the Western Region DCFS (1996) requirements. NOJOS requires that a Level A and a Level B or Level C assessment be performed or obtained by the referent prior to the referral.

Medicaid. According to the DFS/DYC (July, 1995), if the program is billing Medicaid for a psychological or psychiatric evaluation, the services for a Level C assessment must be performed by a licensed psychologist or physician. A master's-level psychologist may administer the psychological test to the client; however, the psychologist may interpret the tests only under the direct supervision of a licensed psychologist or physician. The supervising psychologist must countersign the written report (DFS/ DYC, July, 1995). Therapy cannot begin until it has been prescribed by a licensed practitioner, but a previous evaluation can be used. Psychosocial data may be collected by licensed certified social workers, social service workers, Registered Nurses (RNs), and Licensed Practical Nurses (LPNs). The assessment itself and the prescription for therapy must be documented by a licensed psychiatrist, psychologist, marriage and family therapist, professional counselor, advanced practice RN, or clinical social worker.

DHS licensing. DHS licensing (June, 1991) requires that the program have a written eligibility policy to include the age and sex of the resident and the needs or problems best addressed by the program and the program limitations. The program shall conduct an assessment prior to admission to include health and family history, medical, social, psychological, and, as appropriate, developmental, vocational, and educational factors.

DHS contract. The DHS contract of Utah requires that a Mental Health Assessment be completed that complies with Medicaid requirements. If the program determines the youth is not appropriate for placement, the program will provide written documentation to the case manger at DYC/DCFS specifying the reasons for the determination. Additionally, the program should have a person who is responsible for coordinating intake.

Summary. Table 2.4 summarizes the NOJOS (1996) standards, and Medicaid and state requirements regarding intake criteria and procedures.

Table 2.4

Summary of Intake Criteria and Procedures

Item	Requirement	Source
Assessment	A Level A assessment is to be done at time of investigation.	Western Region NOJOS
Assessment	A Level B or a Level C assessment should be done prior to applying for admission to the program.	Western Region NOJOS
Assessment	Any Level B assessments must be signed by a licensed practitioner in human services or medicine.	Medicaid
Assessment	Any Level C assessments must be signed by a licensed, doctoral level psychologist or physician.	Medicaid
Assessment	The intake assessment must be signed by a licensed practitioner.	Medicaid
Intake Criteria	The program shall have written eligibility requirements addressing the needs or problems best addressed by the program and the program limitations.	DHS licensing
Intake Criteria	The program's written intake criteria include gender of youth, range of age, DSMIV diagnostic categories that the program is not designed to treat, level of risk to community and other clients, cognitive capabilities of youth, level of parental and/or community support required, judicial and legal requirements, other criminal or antisocial behaviors that do not preclude admission such as fire setting, assault, and so forth	Western Region
Intake Procedures	If youth is determined to be not appropriate for placement, written documentation shall be provided to the DYC/DCFS case manager specifying reasons for determination.	Western Region DHS contract
Intake Procedures	If youth is not accepted, caseworker and monitor shall receive written suggestions for alternative programming.	Western Region
Intake Procedures	Program should conduct a sex offender specific intake assessment, which includes a JSO-specific assessment form and interview.	Western Region
Intake Procedures	Programs shall have a person responsible for coordinating intake.	Western Region DHS contract
Intake Procedures	Youth and parents/guardians should receive written copies of program procedures and goals.	Western Region

Treatment Constellation

Literature on treatment constellation describes the processes of treatment planning, treatment strategies, and treatment dosages.

Literature. The literature gives numerous examples of treatment strategies and subsequent goals used for JSOs. The most prominent theoretical model used in treatment is the cognitive distortion model (Lakey, 1992). Cognitive therapists use words such as "victim empathy," "cognitive distortions," "thinking errors," and "cognitive restructuring." Ninety-six percent of the treatment programs sampled by Freeman-Longo et al. (1994) endorsed working on victim empathy; 88% reported working on cognitive distortions, and 80% reported working on thinking errors.

Yochelson and Samenow (1976) hypothesized that offenders of all types use dysfunctional thought processes or "cognitive distortions" to enable and justify the offending behavior. Yochelson and Samenow also pointed out that offenders tend to make certain common thinking errors. The offender may have a "closed channel" (closed mind), maintaining secrecy and self-righteousness that prevent any constructive change from occurring. The offender may withhold the truth by sidestepping, agreeing with others, omitting important details, exaggerating, distorting, and so forth. When listening to others, the offender may select the information he or she wants to hear and distort it. He or she may view any type of dependency as a form of weakness, unwilling to admit any need to others. These and other beliefs may contribute to the offending behavior, and there is a need to restructure these beliefs through therapy.

There is a need to empirically validate the presence of cognitive distortions (Winrott, 1996). Barbaree and Cortoni (1993) developed the Denial and Minimization Checklist based on a typology of adult offenders. In an examination of 20 JSOs, Barbaree and Cortoni found that only 2 of the group did not use denial or minimization. Perhaps the best work affirming the presence of cognitive distortions has been in the area of date rape. Muehlenhard and Linton (1987) demonstrated that young adults who disclosed more sexual aggression were more traditional on the Attitudes Toward

Women Scale and showed more elevated scores on the Acceptance of Interpersonal Violence Scale, the Adversarial Beliefs Scale, and the Rape Myth Acceptance Scale. Clinicians working with JSOs, however, have often noted the presence of distorted thinking about women, sexuality, child readiness, and the effects of sex abuse (Winrott, 1996).

The most studied cognitive distortion is a general inability to empathize with others (Graves, 1993; White & Koss, 1993). JSOs have a tendency to project blame almost totally onto the victim and abdicate responsibility for their own behavior. This appears to be particularly a problem with adolescents who rape peers (G. Wenet as quoted in Knopp, 1982, p. 47).

The most widely used cognitive strategy in treatment is "sexual assault cycle work" (Lane, 1991; Ryan, Lane, Davis, & Isaac, 1987). The "sexual assault cycle" describes a repetitive chain of dysfunctional thinking and behaviors that can be interrupted through awareness and individual effort. Eighty-five percent of the programs sampled by Freeman-Longo et al. (1994) utilize sexual assault cycle work. The cycle is believed to follow this pattern:

1. The sexual assault cycle begins with a "negative self-image stage." At this stage, negative thoughts about the self increase the probability of maladaptive coping strategies when confronted with negative responses to him or herself.

2. During the second stage, the "prediction rejection stage, " the negative self-image leads the individual to predict a negative reaction from others.

3. The individual attempts to protect her or himself through withdrawing from social contact (the isolation stage).

4. Once in isolation, the adolescent begins to fantasize in order to compensate for feelings of powerlessness or lack of control (fantasy stage).

5. During the course of fantasizing, the adolescent begins to visualize the offense, setting the stage for the actual offense.

6. Finally, the sexual offense is carried out, leading to more negative self-imaging and thoughts of rejection.

Another common treatment strategy is "relapse prevention." Relapse prevention was listed by Freeman-Longo et al. (1994) as a tool used by 39% of treatment programs. The "relapse prevention model" first gained prominence in the substance abuse field (Marlett & Gordon, 1985). The relapse prevention model has three goals: (a) to increase the clients' awareness and range of choices concerning their behavior; (b) to develop specific coping skills and self-control capacities; and (c) to create a general sense of mastery or control over their lives (Pithers & Cumming, 1995). The term "relapse" has two different usages. As a noun, it refers to a terminal state about which little can be done. As a verb, it refers to a minor setback in an active process of reform (Pithers & Cumming). The relapse prevention model refers to minor setbacks as "lapses." Relapse prevention includes intervention procedures that are designed to help clients anticipate and cope with the occurrence of lapses and to modify the antecedents of lapses.

A major assumption of relapse prevention is that sexual offenses are rarely impulsive acts. Precursors to the act exist, including anger, boredom, or alcohol. The offender then begins to deal with his or her feelings by having an abusive fantasy, which in turn leads to passive planning. The idea becomes more compulsive, and the offender has a need to justify the thought with a cognitive distortion. The cognitive distortion disinhibits the offender, so that an abusive act occurs (Pithers & Cumming, 1995).

Another assumption of the relapse prevention model is that one can covertly set up a lapse, or relapse, by making a series of seemingly unimportant decisions (SUDs). Offenders who are not prepared to cope with a SUD may attempt to hide their error from the therapist or parole office, leading to additional lapses that are even closer to reoffending.

The major mediating mechanism in the transition between lapse and relapse is identified as the "abstinence violation effect" (Ward & Hudson, 1996). Offenders who accept that there are no "cures" for sexual offenders and view lapses as opportunities to enhance self-management skills through self-examination are considered to be of lesser risk than other offenders.

Gray & Pithers (1993) outlined a relapse prevention program for sexually aggressive adolescents that includes an internal, self-management group and an external, supervisory group.

The internal, self-management treatment group teaches the juveniles about SUDS, high-risk factors, lapses, abstinence violation effect, and coping strategies. The external, supervisory group organizes the collaboration between mental health professionals, probation officers, and family members. These external supervisors become a prevention team that gives the juvenile feedback about risk behaviors observed in the home, community, and school.

Another model used in treatment is behaviorism. The behaviorism model seeks to condition deviant arousal to some repulsive image or sensation. It is often used in conjunction with cognitive models. The two most popular methods are covert sensitization and satiation.

In the Freeman-Longo et al. (1994) survey, covert sensitization was the most widely used behavioral method, with 41% of the programs using it. Covert sensitization uses imagery to disrupt behaviors antecedent to the offenders coming in contact with his or her victim. The procedure requires the offender to imagine and verbalize on tape the various feelings or experiences that lead him or her towards committing a deviant sexual act. The offender then immediately brings to mind aversive images that reflect the negative consequences of proceeding in that direction (Becker, Kaplan, & Kavoussi, 1988; McConaghy, Blaszczynski, Armstrong, & Kidson, 1989). Some programs use scenes that by themselves bring strong nausea reactions. Offenders are observed to grimace, swallow, squirm, and show general signs of nausea (Dougher, 1995). The idea of covert sensitization is to counter condition deviant stimuli so that they lose their capacity to reinforce sexual behavior (Dougher, 1995).

Verbal satiation, a technique used often by Becker (Becker et al., 1988), is another cognitive-behavioral technique. Verbal satiation teaches the offender to use deviant thoughts in a repetitive manner to the point of satiating himself or herself with the very stimuli that he or she may have used to become aroused. The satiation technique of Becker et al. requires the subject to look at a slide depicting a deviant target while repeating a deviant phrase. The deviant phrase is based on the referral source's report of the nature of the deviant act. Following satiation, subjects process how to appropriately engage in behaviors in the future. Verbal satiation is used by 18% of programs surveyed by Freeman-Longo et al. (1994).

Social skills training appears to be an essential component of JSO treatment. Freeman-Longo et al. (1994) listed social skills training as a modality employed by 92% of JSO programs. Two social factors in JSOs investigated by Miner and Crimmens (1997) point to high need for social skills training. First, sex offenders, when compared to nonoffending and delinquent youth, are more likely to be isolated from both peers and their families. Second, sex offenders, when compared to nonoffending and delinquent youth, have more negative attitudes about deviant behavior. In committing a sexual crime, the juvenile offender violates his or her own generally prosocial belief structure (Miner & Crimmens).

One of the realities of treatment constellation provided by residential programs was elaborated on in a large national study of JSO correctional programs by Sapp and Vaughn (1990). These authors found differences between the treatment constellation offered, and the treatment constellation the program directors would like to offer. Specifically, the program directors would offer more behavior modification components, but they are limited by political and economical realities.

I examined the treatment modalities provided at the Hennepin County Home School in Minnetonka, Minnesota (Heinz et al., 1987) and the Echo Glen Children's Center in Snoqualimie, Washington (Knopp, 1982). These facilities are roughly equivalent to Level Six programs in target population and scope. Common themes among the treatment modalities included cognitive restructuring, disclosure of offense history, empathy training, social skills training, sex education, sexual behavior and deviant arousal, sex role stereotyping, and the resolution of loss and grief issues (Heinz et al., 1987; Knopp, 1982; Thomas, 1992). All of the programs provided education and recreational opportunities. The Gibault School had separate components for offenders with below average IQ as well as above average IQ (Thomas, 1992). None of the programs mentioned behavioral techniques such as satiation or covert sensitization. The bulk of time at the schools was spent in group therapy and daily living training, with individual therapy as an adjunct.

Western Region. The Western Region DCFS (1996) divide their discussion of standards into the areas of treatment goals, treatment modalities, and treatment comprehension. The list of

treatment goals drew from the sex offender-specific treatment goals posited by the National Task Force on Juvenile Sexual Offending (1993). The list is lengthy, and includes themes of remediating cognitive distortions, reducing deviant arousal, relapse prevention, increasing interpersonal and personal competency, and decreasing exploitative behaviors. Treatment modalities should consist of (a) cognitive strategies to include relapse prevention and sexual assault cycle work; (b) skills development services; (c) behavioral strategies to reduce deviant arousal; (d) sex education to include discussions about AIDS and sexually transmitted diseases; (e) group therapy; (f) individual therapy; (g) family therapy; (h) adjunct therapies such as nursing and psychiatric service as needed; and (I) recreation. Regarding the area of comprehension of treatment constellation, the Western Region DCFS specify that (a) the youth and the staff should be able to articulate the goals, processes, and rules of therapy, and (b) there should be good communication about treatment between staff members and caseworkers as facilitated by good documentation and clinical staffings. Caseworkers should be invited to at least two staffings per month.

NOJOS. NOJOS (1996) addressed the issue of treatment constellation by identifying a large number of sex offender-specific treatment goals listed by the National Task Force on Juvenile Sexual Offending (1993) that should be a focus of treatment with every JSO. The Western Region's standards included a synopsis of these goals. NOJOS specifies that the treatment goals of each juvenile sex offender should include the full range of treatment objectives. NOJOS further specifies the treatment modalities that should be part of Level Six treatment and the frequency with which these modalities should occur. The modalities and frequency recommended by NOJOS are found across the "Treatment dosages" row in Table 2.5.

Medicaid. Medicaid requirements (DFS/DYC, July, 1995), in contrast to NOJOS requirements, focus on the process of treatment planning. An important requirement of the process is that the person developing and signing the plan must be properly credentialed. Mental health treatment plans can be signed only by practitioners (licensed psychiatrist, psychologist, marriage and family therapist, professional counselor, advanced practice RN, or clinical social worker).

Table 2.5

Summary of Treatment Constellation Requirements and Recommendations

Item	Requirement	Source
Treatment planning	Each treatment plan should focus on the full range of sex offender-specific objectives.	NOJOS
Treatment planning	Mental health treatment plans must be signed by a licensed practitioner.	Medicaid
Treatment planning	Skills development treatment plans can be signed by a licensed practitioner or a person certified to provide skills development services.	Medicaid
Treatment planning	Each treatment plan should be individualized.	DHS licensing Medicaid
Treatment planning	Treatment goals should be measurable, with performance time frames and limitations derived from assessment information.	DHS licensing
Treatment planning	There should be evidence in the treatment plan that the individual and family participated in formulating the objectives (unless clinically contraindicated).	DHS licensing
Treatment planning	The treatment plan should specify the methods used to evaluate progress on the plan.	DHS licensing
Treatment modalities/dosages	Sex offender-specific group therapy should occur at least twice weekly.	NOJOS DHS contract
Treatment modalities/dosages	Life skills training should occur at least 3 hr daily.	DHS contract
Treatment modalities/dosages	Individual therapy should supplement group therapy and occur one to two times weekly.	NOJOS DHS contract
Treatment modalities/dosages	Family therapy or multifamily therapy should occur at least twice monthly.	NOJOS DHS contract
Treatment modalities/dosages	Recreational activities should occur at least twice weekly.	DHS contract
Treatment modalities/dosages	Accredited academic education should occur daily.	DHS contract

(table continues)

Item	Requirement	Source
Treatment modalities/dosages	A relapse prevention group should occur at least once weekly.	NOJOS
Treatment modalities/dosages	Sex education including AIDS and STD information should be included in treatment.	Western Region, NOJOS
Treatment modalities/dosages	Treatment should include sexual assault cycle work.	Western Region
Treatment modalities/dosages	Behavioral strategies to reduce deviant arousal should be included in the treatment constellation.	Western Region, NOJOS
Treatment comprehension	Youth should be able to articulate treatment goals, processes, and rules.	Western Region
Treatment comprehension	Staff should be able to articulate treatment goals, processes, and rules.	Western Region, DHS licensing
Treatment comprehension	Therapy sessions should be well documented.	Western Region, Medicaid
Treatment comprehension	Clinical staffings should be held weekly.	Western Region, DHS contract
Treatment comprehension	Caseworkers should be invited to at least two clinical staffings per month.	Western Region, DHS contract

Skills development is defined as rehabilitative services provided to a client or group of clients in a residential program, a day treatment program, or other appropriate setting to assist clients to develop competence in basic living skills and to help clients develop appropriate interactional skills for skills development services. Skills development treatment plans can be signed by practitioners or other health care workers, specifically licensed certified social workers RNs, social service workers, certified provider of rehabilitation services for children. A statement of disability and need for treatment must be made. The goals should be measurable. How long treatment is believed to be needed must be specified. Medicaid encourages clinicians to write treatment goals that are individualized, rather than generic for a group of clients.

DHS licensing. DHS licensing (1991) specifies that treatment plans be individualized. The goals and objectives of the plan should be measurable, with performance time frames and limitations derived from assessment information. There must be evidence that resident input was considered in identifying goals or objectives. Further, the family should be involved (unless clinically contraindicated). The treatment plan should specify daily activities, services, and treatment. Finally, the treatment plan should specify methods for evaluating progress on the treatment plans. Staff who provide direct care should be informed of the treatment plan.

DHS contract. The DHS contract specifies and defines types and frequency of modalities. These specifications are the same as the NOJOS specifications. Three additions to the NOJOS specifications include (a) recreational activities to be included twice a week and (b) the involvement of the youth in an accredited educational program and (c) Skills Development Services should be provided 3 hr daily. The contract recommends that, ideally, a male and female therapist team should facilitate the group. The treatment constellation should address issues of sex education, AIDS, and STDs. Clinical staffings should be held weekly, and caseworkers from DCFS or DYC should be included in a least two clinical staffings per month.

Summary. Table 2.5 summarizes the standards of NOJOS and the requirements of Medicaid and the State of Utah regarding treatment constellation.

Supervision

Supervision refers to the degree of physical control exercised over the offender. It includes the type of custody arrangement, the degree of control offered by the physical environment, physical monitoring, and behavior management.

Literature. The literature is clear on the subordination of the offender's need for treatment to the needs of the community and victim for safety (Barbaree & Cortoni, 1993; National Task Force on Juvenile Sexual Offending, 1993). However, only one mention of guidelines in the literature regarding supervision within residential programs could be found. The National Task Force on Juvenile Sexual Offending (1993) discussed the need for supervision within the facility to prevent

residents from perpetrating on each other. It cautioned programs to consider room assignments carefully, with sharing a private room being considered a privilege based on progress in treatment. JSOs, according to the opinion of most of the panel involved in the National Network on Juvenile Sexual Offending (1993), should initially be housed in dorms of three or more or in individual rooms. Toilets and showers should be planned for personal privacy as well as collective safety. Awake night staff should monitor residents both randomly and at frequently planned intervals throughout the night.

In examining the three JSO residential programs that are similar in target population and scope to Level Six programs, the author could find only one program (Hennepin County Home School--Heinz et al., 1987) that described the staff to client ratio. Hennepin County School used a 1:8 staff to residents ratio at all times during programming hours, and a 1:8 staff to residents ratio in the schools. Two programs, the Gibault School and the Echo Glen Children's Center (Thomas, 1992), had level systems through which privileges served as a gambit for good behavior. The Echo Glen Children's Center described having a program violation process, though it did not elaborate on what that process was. None of the programs reported training parents on home visits.

Western Region. The Western Region DCFS (1996) scrutinizes the intensity and structure of Level Six programs supervision. The Western Region specifies that there should be 1:3 staff to client ratio during day hours and 1:5 staff to client ratio after hours. The program should maintain staff logs or time sheets to document 24 hr awake supervision. The program should be able to limit further offending behaviors by use of a physical monitoring system and the self-containment of schooling and other services. The program should have a comprehensive program master manual and a documented behavior management system. The documented behavior management system should have levels with entrance and exit behaviors, and a means of communication between staff and youth regarding progress within levels. The program should have written rules regarding residents' behaviors in the bedroom, bathroom, and among themselves. Additionally, the program should have written policy and standards regarding room assignment. The youth should

have written copies of program rules, and should be able to articulate the program rules. Staff also should be able to articulate rules.

Programs should have a written policy stating the program violation process. The program staff should communicate all infractions of rules with each other. The program should document attempts to carry out consequences. Youth and parents should be given the opportunity to protest consequences through a written grievance procedure. In the event that a youth is expelled from a program, therapists should make recommendations to caseworkers for other programming.

Home visits should take place only after the parents/custodians are trained on supervision requirements. The supervision requirements during home visits should be written, and the supervision training should be documented.

NOJOS. NOJOS (1996) specified that custody of Level Six residents is usually with DCFS or DYC. The youth's compliance with the treatment plan is monitored by the juvenile justice authority, a multidisciplinary team consisting of specialists in therapy, law enforcement, law making, education, and so forth. If the youth fails to progress through treatment in a timely fashion, he or she may be referred for more intensive treatment or supervision. The standards of progress include accomplishment of the specific treatment goals and objectives, cooperativeness in treatment, maintaining control and self-responsibility, changes in thinking, and observable changes of behavior over time.

DHS licensing. DHS licensing (June, 1991) listed specifications regarding behavior management in residential care. The requirements of the Office of Licensing indicate that the program shall have a written policy and procedure for methods of behavior management to include: (a) the definition of appropriate and inappropriate behaviors of residents, (b) acceptable staff responses to inappropriate behaviors, and (c) the use of physical restraint. Physical constraint should never be used as a punishment or a means of frightening or humiliating a resident. Rather; it should be used a passive means to temporarily physically restrain in order to protect the resident, other persons, or property from harm.

DHS licensing also gives specifications regarding the physical environment of the residential care facility. The physical facility should provide separate living space with a private bathroom for live-in staff. The program shall have space to serve as an administrative office for records, secretarial work, and bookkeeping. Indoor space for free and informal activities of residents shall be available. Provision shall be made for resident privacy. Space shall be provided for private and group counseling sessions.

No more than four persons should occupy a bedroom, with at least 60 square feet per occupant. Single resident bedrooms should have at least 80 square feet. Sleeping areas shall have a source of natural light and shall be ventilated by mechanical means or equipped with a screened window that can be opened. Beds must be solidly constructed (no portable beds), and must be provided with clean linen weekly.

Bathrooms shall accommodate physically disabled residents, as required. Bathrooms should be ventilated by mechanical means or equipped with a screened window that can be opened. There should be at least one toilet, one lavatory, and one tub or shower for each six residents. The toilets and baths or showers should allow for individual privacy, unless residents require assistance. There shall be mirrors secured to the walls at convenient heights and other furnishings or equipment necessary to meet the resident's basic hygienic needs. Bathrooms shall be so placed as to allow access without disturbing other residents during sleeping hours.

DHS contract. The DHS contract specifies that the program must provide 24 hr awake supervision. Staff to client ratios should be 1:3 daily and 1:5 after hours.

Summary. Specific guidelines for supervision have not been well defined by NOJOS, Medicaid, and the DHS contract; neither has the literature given guidelines much consideration. This is in contrast to the general opinion that community protection is superordinate to treatment considerations. Supervision issues that have received some brief coverage include compliance with treatment, behavior management, staff to client ratios, random and frequent planned room checks throughout the night, room assignments, bathroom planning, behavioral management, and home visits. The most comprehensive guidance on supervision is in the DHS licensing (June, 1991),

which specifies standards for behavior management and physical facilities and Western Region DCFS (1996). Table 2.6 summarizes requirements and recommendations regarding supervision.

Aftercare

The average length of stay in a Level Six program is 12-18 months (NOJOS, 1996). Because the offender becomes accustomed to structure and support, it is important that the JSO has continued support following his or her release from the program. Aftercare refers to the continued treatment of a juvenile sex offender following release from a residential program.

Literature. The National Task Force on Juvenile Sexual Offending (1993) pointed out that aftercare is as essential to the offender's rehabilitation as the initial assessment and treatment. Aftercare provides a therapeutic link to life-time accountability. It recognizes the stress of reintegrating and challenges the youth to maintain treatment gains. Aftercare allows therapists to provide feedback to JSOs as they observe JSOs for changes in behavior that might precede offending. Aftercare, in studies of adult offenders, has been found to decrease recidivism considerably (Steele, 1995). In spite of the importance of aftercare, adequate aftercare programs are generally lacking. The Western Region DCFS (1996) found that adequate aftercare services were not available for Level Six programs in Utah. One of the consequences noted was that programs were keeping the JSOs in treatment longer than necessary. This is unfortunate, as Rasmussen's (1995) study of JSO recidivism in Utah demonstrated that time in residential treatment was associated with increased propensity to reoffend sexually, but less propensity to reoffend nonsexually.

The three programs examined by the author did not have adequate aftercare programs. The Echo Glen Children's Center (Knopp, 1982) expressed frustration at the political and economic realities restricting the provision of adequate aftercare services. They noted that youth in the state were committed to the school for usually only 1 year, which was insufficient time to adequately treat the sexually offending behavior. The families of the youth were scattered all over the state, making it difficult to access services. The staff at Echo Glenn did their best to locate

Table 2.6

Summary of Requirements and Recommendations Regarding Supervision

Item	Requirement	Source
Custody arrangements	Custody is usually with DCFS or DYC.	NOJOS
Behavioral management	The program shall have a written policy and procedure for methods of behavior management to include: (a) the definition of appropriate and inappropriate behaviors of residents, (b) acceptable staff responses to inappropriate behaviors, (c) the use of physical restraint.	Western Region DHS licensing
Behavioral management	Program should have a comprehensive master manual.	Western Region
Behavior management	Program should have a documented behavioral management system.	Western Region
Behavior management	Youth and staff should be able to articulate rules.	Western Region
Behavior Management	Program should have written violation process.	Western Region
Behavior management	If youth is expelled, therapists should make recommendations for other programming.	Western Region
Physical facility	The physical facility should provide separate living space with a private bathroom for live-in staff.	DHS licensing
Physical facility	The physical facility should have space to serve as an administrative office for records, secretarial work, and bookkeeping.	DHS licensing
Physical facility	Indoor space for free and informal activities of residents shall be available.	DHS licensing
Physical facility	Provision shall be made for resident privacy.	DHS licensing
Physical facility	There should be no more than four persons to a bedroom, with at least 60 square feet per occupant.	DHS licensing
Physical facility	Single resident bedrooms should have at least 80 square feet.	DHS licensing
Physical facility	Sleeping areas shall have a source of natural light.	DHS licensing
Physical facility	Sleeping areas shall be ventilated by mechanical means or equipped with a screened window that can be opened.	DHS licensing

(table continues)

Item	Requirement	Source
Physical facility	Beds must be solidly constructed (no portable beds).	DHS licensing
Physical facility	Bathrooms shall accommodate physically disabled residents, as required.	DHS licensing
Physical facility	Bathrooms should be ventilated by mechanical means or equipped with a screened windows that can be opened.	DHS licensing
Physical facility	There should be at least one toilet, one lavatory, one tub or shower for each six residents.	DHS licensing
Physical facility	The toilets and baths or showers should allow for individual privacy, unless residents require assistance.	DHS licensing
Physical facility	Bathrooms shall be so placed as to allow access without disturbing other residents during sleeping hours.	DHS licensing
Monitoring	The program must provide 24 hr awake supervision.	Western Region, DHS contract
Monitoring	Staff to client ratios should be 1:3 daily and 1:5 after hours.	Western Region, DHS contract
Home supervision	Program should have written supervision requirements for parent custodians during home visits.	Western Region
Home supervision	Program should train parents/custodians in supervision requirements.	Western Region
Home supervision	Program should document parent's/custodian's home supervision training.	Western Region

special services within the community to help the offender after release. The Hennepin County Home School (Heinz et al., 1987) does not report a formal aftercare program, but it did report on a young offender returning to a bimonthly retreat after release due to a fear of relapse. The Gibault School (Thomas, 1992) acknowledged that it had an aftercare program but did not describe it.

Western Region. The Western Region DCFS (1996) specified that the aftercare plan should include individual, family, and group counseling as jointly defined and agreed upon by caseworkers and program treatment staff. The program should be able to provide or arrange for therapeutic intervention with youth in custody but living at home or in other community programs. The program should have a step-down programming component. The program should maintain a copy of the youth's aftercare plan, and that plan should be attached with the youth's discharge summary.

Aftercare services should be documented in the client's individual file. The Western Region specifies that the program should have available the full gamut of step-down resources, including Level One, Level Two (outpatient), Level Three (day treatment), and Level Four (group, proctor, or structured home), available within its agency or allied agencies. Finally, the program should track the client's rearrests for both sex and nonsex behaviors after release from the program.

NOJOS. NOJOS (1996) stipulated that JSOs completing a Level Six program should have 6 to 12 months of aftercare. The aftercare, according to NOJOS, may take place in an outpatient treatment program with treatment goals and modalities similar to those given to Level Two offenders. The primary modalities of Level Two are group therapy and parent group sessions, supplemented by individual and family therapy sessions. Individual and offender group sessions should occur weekly. Parent group and family therapy should occur at least bimonthly.

DHS contract. The DHS contract specifies that the program will develop an aftercare plan for the youth that includes individual, family, and group counseling. The treatment plan should be agreed to by DYC staff and program treatment staff. Therapeutic intervention with youth under DYC custody but living at home or in other community programs should be available. The program should have available a copy of the youth's aftercare plan, and the plan should be attached to the youth's discharge summary. If the contractor provides direct services to the youth after discharge, these services should be documented in the client file.

Summary. Aftercare has been noted to reduce recidivism considerably and provide a failsafe for JSOs reintegrating into the community. Some programs in Utah may extend residential care due to inadequate availability of aftercare. Features of aftercare noted by NOJOS and the DHS contract include:

1. For Level Six residents, aftercare should last at least 6 to 12 months.

2. The aftercare of Level Six should to be similar to Level Two treatment, to include groupand parent group treatment as the primary modalities.

3. Level Six programs are required by contract to develop aftercare plans for their youth.

4. Level Six programs should have available aftercare for youth not residing in the facility but still in DYC custody.

5. The aftercare plan should be attached to the discharge summary.

6. If the aftercare will be continued at the facility, the program should maintain a copy of the aftercare plan in the client's chart.

7. Caseworkers should be involved in the aftercare planning process.

8. The program should have step-down resources to include Levels Two (outpatient), Three (day treatment),and Four (group, proctor, or structured home) available within its agency or allied agencies.

9. Aftercare services should be documented in the client's individual file.

10. The program should track former clients' rearrest records for sexual and nonsexual offenses.

Staff Qualifications and Training

The credentials of staff are important not only in assuring quality care but also in helping to maintain the program's financial viability. Standards for therapists and residential staff in the area of juvenile sex offending appear to require specialized skills not required of therapists and residential staff in other mental health endeavors.

Literature. The Hennepin County Home School program (Heinz et al. 1987) reported on the qualifications and training of their staff. The program was reported to consist of two 24-bed cottages. Each cottage is directed by a social worker having a Master's of Social Work (MSW). Additionally, there are two therapists for each cottage, both having MSWs. In addition to the professional staff, each cottage has one correctional supervisor, five full-time line staff, and three part-time line staff. Three additional line staff serve on call.

Heinz et al. (1987) did not mention if the line staff had any type of certification. Each cottage had a half-time recreational therapist. All staff were required to have 80 hr of training during their first year of employment. Thereafter, they were required to have 40 hr of training annually. Twice a

year, staff received training in restraints, such as using breaks, holds and walkalongs. Once each year, staff were trained on suicide prevention.

Western Region. The Western Region DCFS (1996) specified that therapy services should be provided by licensed staff, and that the license credential should be documented in the personnel file. The therapist providing the services should ideally have the qualifications or be a trainee of someone who has the qualifications outlined in NOJOS, 1996. (Note: Western Region states that the qualifications would be outlined in NOJOS Professional Qualifications, 1995, but that document did not come out until 1996.) The program should have available a copy of the therapist's supervised clinical experience working with JSOs, and documentation should be in the personnel file. Finally, the therapist is to sign a program code of conduct.

Requirements for line staff center on training. Line staff should have documented at least 20 hr of preservice training plus 2 hr of basic First Aid and CPR training. Additionally, they should be trained in (a) an orientation to the provider's contract with DHS, (b) applicable federal entitlement requirements, (c) code of conduct, (d) adolescent behavior and development, (e) behavior management and discipline methods, (f) court procedures, (g) parenting skills, (h) the goals of sexual offending treatment, (i) the supervision of juveniles offending sexually, (j) program modalities of treatment, and (k) the program's policy and procedures. The training should be documented. The line staff should have documentation in their charts that they are certified skills development services providers. Finally, the line staff should sign a program code of conduct.

NOJOS. NOJOS (1996) emphasized that JSO specific intervention requires expertise that goes beyond traditional mental health training. Unskilled and unsuspecting therapists are likely to become entrapped in the JSO's system of denial. NOJOS suggests that professionals working with JSOs belong to state networks as well as national organizations such as Association for the Treatment of Sexual Abusers (ATSA), American Professional Society on the Abuse of Children (APSAC), and the National Task Force on Juvenile Sexual Offending.

Medicaid. DFS/DYC (July, 1995) discussed the licensors of treatment providers. In order to prescribe or provide clinical therapy, the practitioner must be a licensed physician, licensed

psychologist, licensed clinical social worker, licensed advanced practice RN, mental health nurse specialist, a licensed marriage and family therapist, or a licensed professional counselor. Additionally, a person who is not licensed but is either enrolled in a program or clinical supervision leading to licensing may prescribe or provide therapy, if supervised by a licensed practitioner.

In order to prescribe or provide skills development services, a provider must be a licensed certified social worker, a licensed social service worker, a licensed RN, a LPN, or other trained individual. Additionally, anyone who is qualified to provide mental health therapy can also provide skills development services.

DHS licensing. DHS licensing (June, 1991) discusses staff qualifications and training in detail. Treatment shall be provided or supervised by professional staff whose qualifications are determined by the governing body, in accordance with state law. The governing body shall ensure that all staff are certified and licensed as legally required. The program shall have a personnel file for each employee to include credentials and certifications, training record, Bureau of Criminal Identification (BCI) checks, Utah Social Services Deliver System Child Protective Services (USSDS) screening, and a signed copy of the code of conduct. Line staff shall be trained in all policies of the program, including orientation in philosophy, objectives, services, and emergency procedures; behavior management; statutory responsibilities of the program; current program policy and procedures; and other relevant subjects. The staff shall also have first aid and CPR training.

DHS contract. In addition to repeating the Medicaid requirements, the DHS contract specifies that a client staffing should be held weekly. At least twice a month, caseworkers from DYC and DCFS should be invited. The program shall have records containing documentation of weekly staffing and documentation that DYC and DCFS staff attended or were invited to attend at least two staffings per month. The staff providing therapy must have supervised clinical experience working with JSOs. The program shall have available a copy of the therapist's license and documentation of his or her supervised clinical experience working with JSOs. Residential staff shall have documented, at least 20 hr of preservice training plus 2 additional hrs of basic First Aid and CPR training. An additional 30 hr of training will be completed within the first 12 months and

each year thereafter. Training will include an orientation to the provider's contract with DCFS, applicable federal entitlement requirements, code of conduct, adolescent behavior and development, behavior management and discipline methods, court procedures, first aid, medical and emergency procedures, and parenting skills.

Summary

Table 2.7 summarizes the cumulative recommendations regarding staff qualifications and training.

Conclusion

The development of treatment services for JSOs is still in its infancy. The two big questions are how to predict who needs what intervention, and how that intervention should be delivered.

Implementation research seeks to empirically test the degree to which existing programs follow some standard. When combined with recidivism research across time and across sites, it can yield valuable insights into population concerns and treatment delivery that will ultimately improve the efficacy of treatment and decrease the frequency and morbidity of sexual abuse in our society.

Table 2.7

Summary of Staff Qualifications and Training

Item	Requirement	Source
Credentials	Prescribing or providing mental health therapy can only be done by a licensed practitioner, including: (a) physician; (b) psychologist; (c) clinical social worker; (d) marriage and family therapist; (e) advanced practice RN; (f) mental health nurse specialist; or (g) professional counselor.	Medicaid
Credentials	Providing skills development services can only be done by one of the following: (a) a licensed practitioner; (b) a licensed certified social worker; (c) a social service worker; (d) a licensed RN; (e) an LPN; (f) other trained individual.	Medicaid
Credentials	Professional staff must be licensed or certified according to State law and the governing body.	DHS licensing
Credentials	Staff providing therapy must have supervised clinical experience working with JSOs.	DHS licensing
Documentation	Staff must have a personnel file containing a BCI check, a USSDS check, and a signed copy of the code of conduct.	DHS licensing
Documentation	Program shall have a copy of therapist's license and documentation of their supervised clinical experience working with JSOs.	DHS contract
Training	Staff must be trained in all policies of the program.	DHS licensing
Training	Staff must have CPR and First Aid training.	DHS licensing
Training	Residential staff shall have documented at least 20 hrs of preservice training plus 2 additional hrs of basic first aid and CPR training.	DHS contract
Training	An additional 30 hr of training will be completed within first year and every year thereafter.	Western Region DHS contract
Training	Training should include orientation to the provider's contract, applicable federal entitlement requirements, code of conduct, adolescent behavior and development, behavior management and discipline methods, court procedures, first aid, medical and emergency procedures, parenting skills, the goals of juvenile sexual offending treatment, program modalities of treatment, supervision of juveniles offending sexually, and the program's policies and procedures.	Western Region, DHS contract

CHAPTER 3

METHODOLOGY

This study seeks to create and use an objective and comprehensive instrument for measuring implementation within Level Six treatment programs for JSOs. Recommendations made on the basis of findings from the instrument have numerous intended uses, including (a) helping directors improve their programs, (b) examining the need for increased funding from the Utah State Legislature and other sources, and (c) serving as a base from which longitudinal recidivism research, in the future, might generate conclusions about effective program implementation.

The Sample

A convenience sample consisting of seven of the nine Level Six program sites within the state of Utah was used for the implementation study. These sites include: (a) Adolescent Residential Treatment Center (ARTEC) in Salt Lake City; (b) Family Preservation Institute in Brigham City; (c) Family Preservation Institute in Logan; (d) Heritage in Spanish Fork; (e) Southwest Mental Health in Cedar City; (f) Wasatch Mental Health in Orem; and (g) Weber Mental Health in Ogden. The two Level Six providers that were not included either did not meet the sample requirements of having youth in DYC or DCFS custody or did not agree to participate in the study.

The seven Level Six providers represent a combination of private contractors and county mental health providers. All providers are represented in NOJOS and have participated in reviewing and making suggestions to this study.

Sampling

Each site contained three populations: (a) clinical staff, including psychologists, social workers, marriage and family therapists, advanced practice RNs, mental health nurse specialists, professional counselors, and drug and alcohol counselors; (b) line staff; and (c) youth. Each of these groups provided implementation data during the site visit. The samples within these

populations consisted of only those who signed releases of information and were available at the time of the site visit. Table 3.1 depicts the n in each program of each of the samples, as well as the total population. Table 3.1 shows that 50 out of a total of 98 youth were sampled for the clinical file part of the inventory, and 47 youth were interviewed. The youth who were not sampled were largely from a neighboring state.

Each site contained four different sources of data: (a) client files, (b) written materials, (c) observational materials, and (d) interviews. Client files from the total population of youth under the custody of the State of Utah with signed releases of information from parents or guardians were sampled. Written materials were sampled as needed to respond to the items. These written materials included policy and procedure manuals, therapy manuals, staff schedules, medical logs, training logs, recreational calenders, request for proposal, personnel files, and so forth. Observational data were gathered by touring the facility and ascertaining whether certain specifications were met. These specifications included adequate monitoring systems, bedroom space, bathroom facilities, and so forth. The samples were interviewed. Administrative or therapy staff were interviewed to ascertain practices regarding step-down procedures. Line staff were interviewed as to knowledge of youths' goals in therapy. Line staff were also interviewed about their understanding of bathroom, bedroom, and interpersonal rules. Youth were interviewed as to their understanding of therapeutic goals and understanding of bathroom, bedroom, and interpersonal rules. Additionally, youth were interviewed to identify the length of time at the facility and the number of placements or treatments for sex offending.

The Instrument

An instrument was developed in preparation for onsite evaluations. This instrument, "The Juvenile Sex Offender Program Provider Implementation Tool " (JSOPPIT--Appendix A), was created by using the combined standards and guidelines found in the literature (Network on

Table 3.1

Sample Sizes of Sites

Program	Beds	Youth sampled		Clinical staff	Clinical staff interviewed	Line staff	Line staff interviewed
		Chart	Interviewed				
ARTEC	10	9	7	2	1	7	2
Family Preservation (Brigham City)	8	7	7	2	2	8	2
Family Preservation (Logan)	16	3	1	2	2	15 *	2
Heritage	17	10	10	5	1	5	2
Wasatch	10	8	8	2	2	9	2
Weber	16	8	8	5	2	16 *	1
Southwest	7	5	6	2	1	5	2
TOTAL N	98	50	47	20	11	65	13

* All or most of line staff is part-time.

Juveniles Offending Sexually, Medicaid, DHS contracting, DHS licensing) and a predecessor, "The Quality Assurance Tool " (Appendix B).

The Development of the JSOPPIT

This study was preceded by the "Quality Assurance Project,` initiated by the Western Region DCFS in February 1996. The first goal of the Quality Assurance Project was to assure quality and improve JSO-specific clinical intervention and supervision services of providers of residential programs in the Western Region of the Utah State Division of Child and Family Services by the (a) development of an objective quality assurance tool, (b) development and execution of an objective onsite review process, and (c) drafting of a written report regarding the findings of the onsite review. The second goal was to make conclusions and recommendations for the improvement of Utah State programming for effective and efficient JSO-specific services. The "Quality Assurance Tool" was drafted, and an onsite review of four Level Six programs was completed (Western Region DCFS, 1996).

The evaluative questions. The Quality Assurance Tool was organized around six evaluative questions that addressed the issues of coverage and service accountability. These same six questions are the basic organizer behind the JSOPPIT:

1. Does the program serve the correct target population?
2. Does the program define and enforce guidelines for admission into program?
3. Does the program provide intensive JSO clinical intervention services?
4. Does the program provide intensive nonsecure juvenile sex offender supervision within the community and within the program itself?
5. What is the quality of the program's aftercare services?
6. Do staff members have the training and licensure set forth by the Department of Human Services Office of Licensing (DHS licensing, 1991)?

Operationalization. The Quality Assurance Tool provided a basis for discussion amongst clinicians regarding mutually agreed upon expectations, did not specify the expectations to be evaluated in a manner conducive for assessing program delivery. Specifically, the components measured in the Quality Assurance Tool were lacking in the following criteria for obtaining a measurable instrument (Scheirer, 1994):

1. Components were often specified ambiguously, rather than as behaviors that can be observed. For example, the first guideline suggests that a candidate for Level Six treatment program have documented risk factors depicting the youth as being "more predatory, violent, entrenched in the sexual offending pattern." How are predatory, violent, or entrenched operationalized?

2. Components were sometimes not separate and distinguishable from each other. For example, one of the guidelines states the program shall meet minimum standards of treatment of juvenile sex offenders as specified by the National Task Force on Juvenile Sexual Offending (1993). These standards are then duplicated by other guidelines.

3. Units of measurement were not operationalized. For example, most of the evaluative questions required simple yes/no responses; however, they were rated on a 4-point Likert scale. The rater had to determine subjectively whether to put a "yes " response on "superior" or "quality" or a "no" response on "satisfactory" or "needs improvement."

Components on the JSOPPIT were operationalized with the collaboration of state and national experts in the field of juvenile sex offending. First, the Quality Assurance Tool, with the help of key members of NOJOS, was broken down into basic elements (components) describing the strategies, activities, and behaviors that described implementation. A literature review of standards and guidelines was conducted, and additional elements were added. The list of components was sorted through, and duplicates were removed.

Three types of components in the JSOPPIT required different types of operationalizations. The most basic components required dichotomous responses and could be operationalized by either the implementation or nonimplementation of the particular component. A more complicated type of component to operationalize was weighting. Finally, many of the components were qualitative and required methods of matching verbal or written material with scorable responses.

Most of the questions were simple dichotomous responses. For example, items 3d1 to 3d4 explored the extent of the program's compliance with Medicaid treatment planning procedures. This particular question, found in Figure 3.1, requires a yes/no response.

Compliance in yes/no items was operationalized as "1" for yes and "0" for no. If there were three or more items to a section, an implementation index was computed as the total number of "yeses" divided by the number possible. If there was full implementation of the standards, the resulting number was " 1." If there was not full implementation, the number was less than 1.

Another type of item is a simple check of whether or not the characteristic occurs. This item is distinct from the yes/no question in that it focused more on information than

Item No.	Item	Yes (1)	No (0)	Comments
3d1	Treatment plan contains the credentials of the individuals who will furnish the services.			
3d2	Treatment plan contains a statement of disability.			
3d3	Treatment plan specifies how long treatment is expected to continue.			
3d4	Treatment goals specifies measures to evaluate whether objectives are met.			

Figure 3.1 . A yes/no item.

implementation. This type of item occurs only in question 1 (d) which examines the mental health of the population. Figure 3.2 demonstrates the beginning section of a check item.

For components requiring weighting, key members of NOJOS and national juvenile sex offenders experts were asked to weight the elements of the question (n = 7). The experts were given eight indicators of risk and three indicators from the literature. They were given 40 points to assign between the risk factors, and 15 points between the need factors. The number of points possible was based upon the presupposition that if every risk and need factor was equally indicative of risk or need, 5 points would have been assigned each item. This type of component was used to evaluate coverage accountability--whether the population of the Level Six programs are those representing severe risk to the community and/or great need. Figure 3.3 gives an example of a weighted item.

The operationalization of "risk" in this question was the sum of the total of "1s" (or characteristics noted that the particular youth had at time of intake) multiplied by the weight (or the importance of the item as rated by the panel of experts) divided by the total possible points (40 for risk characteristics and 15 for need characteristics). The number was always somewhere between 0 and 1.

The third type of component required qualitative responses. Three styles of items required qualitative data. A few items requiring qualitative data considered treatment goals. The

Item No.	Item	✓	Comments
1d1	Youth has a diagnosis of the following:		
1d2	ADHD		
1d3	Adjustment Disorder		
1d4	Anxiety Disorder		

Figure 3.2. A check item.

Item No.	Item	1/0	Wt	=	Comments
1a1	Youth used a weapon to commit offense.		10.2		
1a2	Youth inflicted discernable physical harm on victim.		7.8		
1a3	Youth has escalated the frequency, duration, or type of aggression involved in offense.		5		
1a4	Youth used force to coerce victim, such as threats, tricks, or physical confinement.		5.2		

Figure 3.3. A weighted item.

panel of experts from NOJOS asked the researcher to find a way to examine the content of the treatment goals and the depth of the youths' and the line workers' understanding of the treatment goals. The Quality Assurance Tool was problematic in that it attempted to use broad, nonsystematic rater judgment as quantitative data. For example, the rater was asked to examine the case file to ascertain if 26 treatment goals were there or not. The rater also had to put the quality of the writing of the treatment goal along a 4-point Likert scale. No guidelines were given as to how to distinguish between the qualities. Further, treatment goals were not uniformly worded--each clinician had a different way of saying the same thing. The original onsite reviewers found that looking for and finding 26 specific treatment goals was unwieldly and meaningless.

To correct this problem, I, with the collaboration of a large multidisciplinary panel of experts ($n > 40$), developed a database of possible answers, "The Qualitative Summary of JSO Treatment

Concepts" (Appendix A). The experts, who were convened at a September 1996 meeting of the Utah Network on Juveniles Offending Sexually (NOJOS), brainstormed on treatment concepts described by each of the 26 treatment goals. I listed each of the treatment concepts under the goal. Listing the treatment concepts in this manner demonstrated that many of the treatment goals were overlapping. Using the overlapping concepts and the literature, I condensed the 26 specific treatment goals into six categories of treatment goals. These categories included: (a) cognitive distortion work, (b) deviant arousal work, (c) relapse prevention, (d) increasing interpersonal competency, (e) increasing personal competency, and (f) reducing exploitative behaviors. The database comprising the "Qualitative Summary of JSO Treatment Concepts" consists of the six treatment categories and the associated treatment concepts listed by NOJOS members, along with synonyms and varying tenses. The JSOPPIT, rather than requesting whether or not each of the 26 specific treatment goals were in the client file, asked only if the treatment category was there.

Figure 3.4 demonstrates how the JSOPPIT measured compliance with the original 26 treatment goals by using treatment categories. The quality of the treatment goals in general was judged quantitatively. Rather than evaluating the treatment goals along a Likert scale as did the Quality Assurance Tool, the JSOPPIT evaluates whether or not specific Medicaid and DHS Licensure standards for treatment goals have been met.

The youths' and line workers' understanding of the content of treatment goals was operationalized according to the number of treatment concepts identified in a verbal interview. Depth was operationalized as the number of treatment goals that the youth or line worker was able to "remember." Breadth was operationalized as the number of treatment categories those treatment concepts identify. The item eliciting information about the youths' understanding of treatment goals is found in Figure 3.5.

A similar qualitative/interview item addressed the understanding that youth and line workers have regarding program rules. This item, for example, required the enforcer of rules (line staff) to

Item No.	Item	Yes (1)	No (0)	Comments
3 c1	Treatment plan contains objective of remediating cognitive distortions.			
3c2	Treatment plan contains objective of reducing deviant arousal.			
3c3	Treatment plan contains objective of relapse prevention.			
3c4	Treatment plan contains goal of healing personal victimization.			
3c4	Treatment plan contains objective of increasing interpersonal competency.			
3c5	Treatment plan contains objective of increasing personal competency.			
3c6	Treatment plan contains objective of decreasing exploitative behaviors.			

Figure 3.4. Treatment category items.

Item No.	Item	Number	Comments
	(Ask: Tell me about what you are working on in therapy. What are you doing to work on it?)		
3a3	Number of treatment words identified		
3a4	Number of treatment goals identified		
3a5	Number of treatment dimensions identified		

Figure 3.5. Item on youth understanding of treatment goals.

identify which rules he or she thought were most important for youth to follow in (a) the bedrooms, (b) the bathroom, and (c) amongst themselves. Youth were asked the same questions. An audio-taped copy of the youths' response was indexed and matched against key words of the response given by the youth's assigned lineworker. Understanding was operationalized as the number of matches. Figure 3.6 demonstrates the item on program rules.

I met with key members of NOJOS once again to discuss data retrieval. The NOJOS team and the researcher determined that the most efficient and accurate way of accessing the data was to use key persons from within the program to show me where the data could be found. To better organize this process, NOJOS members and I went through each component and

Item No.	Item	Number
	(Ask: Please tell me one or two rules that you consider to be most important for the youth to follow in the bedroom.)	
4e11	Number of matches between youth and primary line worker's response	

Figure 3.6. Program rule item.

determined where the data were likely to be found and which staff position within the program would have access to the required data.

A description of the JSOPPIT. The Juvenile Sex Offender Provider Program Implementation Tool (JSOPPIT) is a 57-page data guide (Appendix A). It consists of a Data Collection Guide, a Data Scoring Guide, and the "Qualitative Summary of JSO Treatment Concepts." The Qualitative Summary of JSO Treatment Concepts has already been described.

The Data Scoring Guide was divided into four main sections according to the general source of data: (a) client file items, (b) written materials items, (c) observational items, and (d) interview items. The word "item" was used in lieu of the word "component" for brevity and ease of understanding. Each of the four main sections was further divided according to the person or persons (administrative, clinical, line staff, or youth) who were used by the evaluator to access the information within the section.

The shaded horizontal rows identified the target area that was being examined by a given set of items. The first column contained a code number to help the researcher match the item on the data collection guide with an item on the scoring guide. The first number in the code represented the target area being examined. The letter in the middle of the code referred to a purpose for the item. (The purposes for all of the items were found in the third column of the scoring guide.) The final number in the code distinguished the item from other items with the same

first number and letter. The second column in the Data Collection Guide consisted of the item. Data were recorded in the middle columns. The final column was reserved for comments, the purpose of which was to help the researcher provide the program with feedback.

The Data Scoring Guide was also divided into the four sections of client file items, written materials, observational data, and interview materials. Further, it was divided according to the person or persons assisting the researcher obtain the data. The Data Scoring Guide was much shorter than the Data Collection Guide because it did not contain every item. Rather, it summarized how a set of items was to be scored. The first column in the Data Scoring Guide contained the item number, a code number to help the researcher match the item with similar items in the main part of the instrument. The second column gave specific sources as to where the data were likely to be found. As programs vary in how they store information, the researcher chose to include general data sources (e.g., client files, written materials, and so forth) as the major organizer for the inventory, and specific data sources (e.g., medical log, accreditation document, Request for Proposal) as possible places to look for the data. The third column described to the researcher the purpose for the item. The final column gave scoring instructions.

Procedures

Two investigators visited each site: (a) an investigator from Utah State University (the author) and (b) an investigator from the Division of Youth Corrections (DYC). An investigator was there from the DYC because (a) he was knowledgeable about program operations, (b) he was neutral regarding the programs, and (c) he represents DYC and has custodial rights over most of the youth assigned to the program.

The JSOPPIT contained both quantitative and qualitative items. The qualitative items required the evaluator to interview human subjects, including (a) administrators, (b) clinicians, (c)

line staff, and (d) juvenile sex offending youth. The DYC investigator obtained all of the qualitative data through interview while the USU investigator collected the quantitative data.

Confidentiality

The identity of individual youth to be interviewed was protected by allowing the youth to speak face to face with only the DYC investigator. The DYC investigator identified the youth by number only. This practice met ethical standards of investigating human subjects, as the State of Utah has custody over youth in the Level Six programs. The identity of the youth was unknown to the USU investigator. The name of the youth on client records was identified by number. The staff member walking the investigator through the client records was to remove identifying information from the chart prior to data collection.

All parties who were interviewed were required to sign releases of information. In addition, the parents or guardians of the youth who were interviewed were required to sign a release of information.

The identity of the individual programs was protected by assigning a number to each program. This protected the information gleaned from each evaluation from being exploited as marketing tools. The focus was on ascertaining the level of implementation in Level Six programs as a whole, and providing individual providers with information regarding their strengths and weaknesses, the areas needing improvement. At the conclusion of the study, each program was informed of both the general outcome of the evaluation over the programs, and the outcome of that specific program in comparison with the other programs. The programs did not, however, know whether that specific program was better or worse than any particular program.

Training

The evaluation was a team effort requiring the expertise of a DYC investigator and program personnel. The collection of quality data was abetted by an evaluative team that understood the purpose and strategies of the evaluative items and that could listen and communicate with each

other. The development of such teamwork required that each participant understood his or her role. Such understanding required training.

Training the DYC evaluator. As the DYC evaluator conducted the interviews, it was important that he was well versed in the questions, the purpose of the questions, and the manner of scoring the questions. An audio-tape was used to record the data collected by the DYC evaluator. The DYC evaluator needed to know how to collect the data and code each audio-tape so that the USU evaluator (the author) could correctly record the data. The DYC evaluator was trained by the USU evaluator in each of these areas prior to the administration of the JSOPPIT.

Training the programs. Prior to the onsite visit, program directors or representatives were sent a letter that outlined the procedures involved in administering the JSOPPIT. Additionally, each program director was contacted by phone to clear the date of the visit and follow up on any questions regarding procedure. At the time of the phone call, the investigator arranged an evaluation schedule around the particular situation of the site. For example, some of the programs had residences and clinical records at two different sites. The investigator needed to arrange to visit both sites. Directors or their representatives were advised as to what records or documents were needed so that the onsite personnel could assemble the information before the visit.

Administering the JSOPPIT

Table 3.2 depicts a sample schedule of the site visit. After initial introductions to the personel onsite, the USU researcher began examining case files. A key person understanding each portion of the chart assisted the researcher in finding the information. For example, a therapist assisted the researcher in finding information regarding the risk and need characteristics. A line staff person assisted the researcher in finding information about skills development. After going through the charts, the USU researcher worked with administrative staff to glean information from written materials such as manuals, brochures, bulletin boards, logs, and so forth. Following interviews with the administrative staff, the USU researcher

Table 3.2

Sample Schedule of Site Visit

Time	USU Researcher	Assistant	DYC Researcher
8:00	Introduction to Staff	----------	Introduction to Staff
8:30	Case File Items	Therapist	Phone Interviews
9:00	Case File Items	Therapist	Staff Interviews
9:30	Case File Items	Therapist	Staff Interviews
10:00	Case File Items	Therapist	Staff Interviews
10:30	Case File Items	Therapist	Youth Interviews
11:00	Case File Items	Therapist	Youth Interviews •
11:30	Case File Items	Line Staff	Youth Interviews
12:00	Case File Items	Line Staff	Youth Interviews
12:30	Lunch	----------	Lunch
1:00	Written Material Items	Administrative	Observational Items
1:30	Written Material Items	Line Staff	Observational Items
2:00	Observational Items	Line Staff	Flexible time

interviewed line staff about the daily living practices of the youth. The USU researcher then toured the facility with the line staff to identify information pertinent to the target area of supervision. The DYC researcher began interviews with line staff or youth. Each case file took 20 to 30 min to examine. Each interview took 10 to 15 min. The DYC researcher used flexible afternoon time to finish any remaining interviews. Program directors had expressed an interest in having the researchers sit in on a group session. Such attendance was arranged if there was adequate time.

Validity and Reliability

Pilot Study

To enhance the validity and reliability and ascertain the workability of the JSOPPIT, a pilot study was conducted on a private JSO residential treatment facility not involved in the evaluation. The pilot treatment facility was paid a small stipend to allow the researchers to test the instrument

on their program. Following the pilot study, the evaluands were asked to provide the researchers with feedback on the instrument. The instrument was fine-tuned to incorporate the experience and feedback gleaned from the pilot study. Results of the pilot study are found in Appendix F.

Validity

Validity in constructing the instrument was maintained by using the input of practitioners and key persons who educated the author of the instrument in the practical realities of the components to be measured. These key persons also reviewed and monitored the development of the instrument to ascertain if it complied with those realities. Validity was also enhanced by the fact that the components are linked to the theoretical rationales that see juvenile sex offending from both cognitive (Yochelson and Samenow, 1976) and multisystemic (Becker et al., 1988) perspectives.

Validity was maintained in the administration of the JSOPPIT by selecting, with the help of key NOJOS members, target persons and positions within each program to interview. The JSOPPIT was administered by a multidisciplinary team, including the USU evaluator (the author) and a DYC evaluator.

Reliability

Reliability was protected by using operational definitions and a carefully designed Data Collection Guide. Intracoder reliability was maintained by having the same investigator code the same set of evaluation questions for all interviews. An independent investigator was hired to administer the JSOPPIT a second time to two of the study sites. Eight case files were examined. Test-retest reliability was .86. The independent investigator also listened to and coded the audio interviews of 8 youth. Test-retest reliability for the audio interviews was .71.

It is recognized that the above measures do not guarantee validity and reliability. However, the steps outlined to protect validity and reliability are among the best and most comprehensive that can be used in a study such as this.

Data Analysis

Table 3.3 lists the various strategies that were employed in analyzing the data. Each of the six evaluative questions was broken down into various items that facilitated the analysis. The items are listed in Table 3.3, and check marks identify which strategies were used.

Interprogram Statistics

Interprogram statistics are those statistical strategies that define differences between the programs. An interprogram statistic referred, for example, to the difference between Program One and Seven on the variable "sexual disorders."

Standard scores. Standard scores, or z scores, were used to help interpret the data. Standard scores indicate how far away, in standard units, each score is from the mean. The mean is always equal to 0 in standard scores. When significant differences were found, standard scores helped interpret the direction of the difference.

Frequency. Frequency refers to "frequency count." This statistic was used, for example, when the unit of analysis was a single item requiring a "yes" or "no," such as "quarterly summary was sent."

Fisher's least significant difference (LSD). LSD was used as a multiple comparison method when significant interprogram differences were found. LSD identified which of the means were significantly different.

ANOVA. One-way analysis of variance (ANOVA) was used to identify significant interprogram differences. ANOVA could identify if there were differences, but it could not identify which programs were significantly different. ANOVA required LSD for the full interpretation.

Percentage. Percentage in this context refers to the number of client files in a program meeting a criterion divided by the total number of client files in the program. Percentage was used any time the source of data was client files.

Table 3.3

Data Analysis

	Interprogram					Items			Whole sample		
Standard score	Frequency	LSD	ANOVA	%	Mean	Implementation index	LSD	ANOVA	%	Mean	Standard deviation	Frequency
TARGET AREA 1: TARGET POPULATION												
1. Do the programs provide services for juveniles who present a level of risk appropriate for inclusion in a Level Six residential program (1a1 through 1a8)?												
√		√	√	√			√	√	√			
2. Do the programs provide services for juveniles who present a level of need appropriate for inclusion in Level Six residential program (1b1 through 1b3)?												
√		√	√	√			√	√	√			
3. What mental health problems describe this population (1c1 through 1c15)?												
√		√	√	√			√	√	√			
4. Are required assessment protocols present in the client files (1d1 through 1d2)?												
√			√	√					√			
5. What are the victimization experiences of the youth (1e1 to 1e8)?												
√		√	√	√			√	√	√			
6. What have been the sexual offense experiences of these youth (1f1 to 1f8)?												
√		√	√	√			√	√	√			

(table continues)

	Interprogram						Items			Whole sample		
Standard score	Frequency	LSD	ANOVA	%	Mean	Implementation index	LSD	ANOVA	%	Mean	Standard deviation	Frequency
7. What percentage of the youth have had one, two, or three or more residential placements (1g1 to 1g3)?												
√		√	√	√			√	√	√			
8. What are the average treatment/placement experiences of the youth (1h1 to 1h3)?												
√			√							√		
TARGET AREA 2: INTAKE CRITERIA AND PROCESS												
1. Do the program's written intake criteria conform with DHS guidelines and recommendations suggested in the literature (2a1 to 2a7)												
	√											√
2. Do the programs have good practice intake procedures (2b1 to 2b3)?												
	√											√
TARGET AREA 3: TREATMENT CONSTELLATION												
1. Have youth signed a treatment plan (3a1 and 3a2)?												
				√					√			
2. To what extent do youth and line staff understand the content, depth, and breadth of the youth's treatment plan (3a3 through 3a5; 3b1 through 3b3)?												
				√						√	√	√

(table continues)

	Interprogram						Items		Whole sample			
Standard score	Frequency	LSD	ANOVA	%	Mean	Implementation index	LSD	ANOVA	%	Mean	Standard deviation	Frequency
3. What is the extent to which the treatment goals for the youth meet the minimum requirements of National Task Force on Juvenile Sexual Offending (1993) and NOJOS (1996) (3c1 through 3c7)?												
√		√	√	√		√	√	√	√			
4. What is the extent of the program's compliance with Medicaid treatment planning procedures (3d1 through 3d12)?												
√		√	√	√		√	√	√	√			
5. Do programs have a master therapy manual (3e1)?												
	√								√			
6. Does family therapy meets contractual and NOJOS requirements (3f1, 3f2) ?												
	√								√			
7. Is a quarterly summary of treatment plan sent to DCFS or DYC (3g1)?												
	√								√			
8. Does program therapy meets NOJOS and DHS contract requirements (3h1 through 3h9)?												
				√		√		•	√			
9. Does individual therapy meets NOJOS and DHS contract requirements (3i1 through 3i4)?												
				√		√			√			
10. What is the extent to which the provision of adjunctive therapy modalities meets contractual and NOJOS requirements (3j1, 3j2)?												
	√								√			

(table continues)

Interprogram							Items		Whole sample			
Standard score	Frequency	LSD	ANOVA	%	Mean	Implementation index	LSD	ANOVA	%	Mean	Standard deviation	Frequency
11. What is the extent to which life skills training/day treatment meets contractual and NOJOS requirements (3k1 through 3k3)?												
						√			√			
12. What is the extent to which recreational activities meet contractual and NOJOS requirements (3l1, 3l2)?												
	√								√			
13. What is the the nature of youth's educational placements (3m1 through 3m6)?												
	√								√			
TARGET AREA 4: SUPERVISION												
1. Do staff maintain adequate control of the facility during the day as well as at night (4a1, 4a2) ?												
	√								√			
2. Is the physical environment adequate as a supervision modality (4b1 to 4b13)?												
	√								√			
3. Do the programs have adequate monitoring systems (4c1 to 4c3)?												
	√											
4. Do the programs have an adequate behavioral management system (4d1 to 4d7?												
	√								√			
5. To what extent do youth and line staff understand bedroom, bathroom, and interpersonal rules (4e1 to 4e14)?												
√	√				√						√	√

(table continues)

Interprogram							Items		Whole sample			
Standard score	Frequency	LSD	ANOVA	%	Mean	Implementation index	LSD	ANOVA	%	Mean	Standard deviation	Frequency
6. Does the program have an adequate violation process (4f1 to 4f7)?												
	√								√			
7. Does the program monitor behavior adequately during home visits (4g1; 4g2)?												
	√								√			
TARGET AREA 5: AFTERCARE												
1. To what extent do programs meet the availability of aftercare requirements set by NOJOS (1996) (5a1 to 5a4)?												
	√								√			
2. To what extent do the programs offer "good practice" aftercare modalities (5a5 to 5a8)?												
	√								√			
3. Is the duration of aftercare services adequate (5a9)?												
	√								√			
4. Do the programs adequately document aftercare services (5b1 to 5b4)?												
	√								√			
5. Are the programs' efforts to track recidivism adequate (5c1, 5c2)?												
	√								√			

(table continues)

Standard score	Interprogram: Frequency	Interprogram: LSD	Interprogram: ANOVA	Interprogram: %	Interprogram: Mean	Interprogram: Implementation index	Items: LSD	Items: ANOVA	Items: %	Whole sample: Mean	Whole sample: Standard deviation	Whole sample: Frequency
TARGET AREA 6: STAFF QUALIFICATIONS AND TRAINING												
1. Do the programs' therapists and staff have BCI and USSDS background checks updated yearly (6a1, 6a2, 6b1, 6b2)?												
	√								√			
2. Do the programs' therapists meet professional requirements (6a3 to 6a5)?												
	√								√			
3. Do the programs' line staff meet professional requirements (6b3 to 6b5, 6c1 to 6c12)?												
	√								√			

Mean. The mean, as an interprogram statistic, was used in qualitative data to describe the average response of the program. For example, the mean was used to compare the programs on number of treatment words.

Implementation index. An implementation index is a similar statistic to percentage. It was used when the source of data was not client files. It describes the number of separate items meeting a criterion divided by the number possible; for example, when ascertaining a program's compliance with Medicaid treatment planning procedures. Each Medicaid treatment planning criterion counted as "1," to be added up and divided by the total number of Medicaid treatment planning procedures.

Items

The term "items" refers to the exploration of statistical differences between the items or variables. For example, a statistical difference was explored between the "items" comprising risk characteristics. Two statistics were used to explore differences in items. One-way ANOVA was used to identify the presence of statistical differences; and LSD was used to identify which programs were responsible for the statistical difference.

Whole Sample

"Whole sample" refers to the total N of the programs, client files, or interviews. There were 50 client files, 47 youth interviews, 13 line staff interviews, and seven programs. The terms "percentage," "mean," and "frequency" have been previously explained. The difference in the whole sample context is in the unit of analysis. The term that has not been yet explained is "standard deviation." Standard deviation refers to the squared error (or variation of the scores from the mean).

Weighted Scores

Weighted scores, in addition to other statistical analyses, were used for the items of risk characteristics and need characteristics. For these items, an affirmative response was multiplied

by the weight that was determined by the panel of experts. As there were 40 possible points for risk characteristics, the resulting score was divided by 40. As there were 15 possible points for need characteristics, the resulting score was divided by 15. The closer the average weighted score was to 1, the greater the risk or need posed by the population of Level Six youth.

CHAPTER 4

RESULTS

Implementation research is a unique method of evaluating the effectiveness of a program in meeting a given set of standards and guidelines relevant to the population it serves. It is not to be confused with program effectiveness when one considers "outcome" as measured clinically. However, recognizing that programs must have standards and guidelines to facilitate "outcome," implementation research becomes a critical first point of investigation. This was particularly the case with Level Six residential centers in the State of Utah since research investigating these residential programs has not been previously initiated. Extant research suggests that this is true across the United States.

This study includes an examination of six foci dealing with program management (NOJOS, 1996). These foci include specific requirements as set forth by DHS contracts and Medicaid requirements, as well as guidelines recommended by NOJOS, and the Western Region DCFS (1996).

Target Population

The first evaluative question, "Does the program serve the correct target population," addresses coverage accountability. Coverage accountability, according to Rossi and Freeman (1985), examines the following questions: Are the persons served those who are designated as targets? Are there beneficiaries who should not be served? Coverage accountability was accessed by exploring the (a) characteristics of the offender that indicate risk to reoffend, (b) characteristics of the offender that indicate a need for a nonsecure residential treatment program, (c) mental health characteristics of the target population, (d) procedure that is used in assessing risk/need, (e) experiences of the offender as a victim, (f) experiences of the offender as a perpetrator, and (g) treatment and placement experiences of the sample.

Risk Characteristics

The Network on Juveniles Offending Sexually (NOJOS, 1996, p. 15) described Level Six residents as having displayed "predatory or fixated patterns of offending," "use of force or weapons in committing their sex offenses," "severe sexual acting out in terms of duration and intensity," and/or a "propensity to (sexually) act out with same-aged peers besides their victims." Risk characteristics are defined as factors in the juvenile's sex offense that warrant his or her placement in a residential treatment facility. Table 4.1 lists risk characteristics, as espoused by the experts, from greatest to least risk. Risk characteristics are described for each program as well as the sample.

Only statistically significant data will be presented in the results section. The reader, however, is encouraged to examine the tables, which highlight not only significant results but also percentages, program means, and weighted scores.

Weighted risk scores. Weighted risk scores were computed for each of the groups and the sample at large (see Table 4.1). The weighted risk can be interpreted as the sample's distance between no offenders having any risk characteristics as a group (0) and all offenders having all of the risk characteristics (1). Appendix C, Figure C.1, presents the weighted risk scores of the programs graphically. Programs 4 and 6 had the highest weighted risk (.67 and .68, respectfully), and Program 2 reported the least weighted risk score (.44). The average weighted risk score for the sample was .57.

Comparison of risk characteristics in the sample. The percentages of juvenile sex offenders involving specific risk factors in their offense ranged from a high of 96% (grooming behaviors) to a low of 22% (use of weapon). The data show that a majority of youth in Level Six programs groomed their victims (96%); repeated the sexual assault cycle of a previous offense (90%); escalated the frequency, duration, or type of aggression used in the offense

Table 4.1

Percentage of Offenders with Specified Risk Characteristic by Program

	Program								
	1	2	3	4	5	6	7	M	
Item	n=7	n=3	n=10	n=8	n=9	n=8	n=5	N=50	F
Used weapon	29%	0%	20%	38%	0%	13%	0%	22%	.98
Standard score	.50	-1.57	-.14	1.14	-1.57	-.64	-1.57	0.00	
Inflicted discernible physical harm	29%	0%	40%	25%	44%	75%	40%	40%	1.22
Standard score	-.46	-1.67	0.00	-.63	.17	1.46	0.00	0.00	
Used force to coerce	43%	67%	90%	88%	100%	100%	40%	80%	3.53**
Standard score	-1.54	-.54	.42	.33	.83	.83	-1.67	0.00	
Escalated the frequency, duration, or type of aggression	71%	100%	80%	100%	78%	63%	80%	80%	.73
Standard score	-.29	.65	0.00	.65	-.06	-.55	0.00	0.00	
Had multiple child victims	100%	100%	70%	75%	89%	88%	80%	84%	.65
Standard score	.50	.50	-.44	-.28	.16	.13	.12	0.00	
Repeated sexual assault cycle of previous offense	100%	67%	100%	100%	89%	63%	100%	90%	2.23
Standard score	.29	-.68	.29+	.29	-.03	-.79	.29	0	
Had at least one nonconsensual peer victim	43%	67%	70%	13%	67%	0%	80%	46%	3.75**
Standard score	-.10	.70	.8	-1.10	.7	-1.53	1.13	0	
Used grooming behavior	100%	100%	90%	100%	89%	100%	100%	96%	.53
Standard score	.12	.12	-.18	.12	-.21	.2	.12	0	
F									26.78***

(table continues)

	Program								
	1	2	3	4	5	6	7	M	
Item	n=7	n=3	n=10	n=8	n=9	n=8	n=5	N=50	F
Weighted risk	.53	.44	.59	.68	.56	.67	.49	.57	.90
Standard score	-.43	-1.5	.3	1.4	-.13	1.28	.91	0	

* $p \leq .05$

** $p \leq .01$

*** $p \leq .001$

(80%); had multiple child victims (84%); and used force to coerce those victims (80%). About half (46%) of the juveniles had at least one nonconsensual peer victim. The juvenile offenders were least likely to have used a weapon (22%) and inflicted discernible physical harm (40%).

One-way analysis of variance (ANOVA) and LSD were performed on the risk characteristics to distinguish whether any were significantly different. Standard scores were used to interpret significant differences. The standard scores represent the standardized difference of each score from the mean. It should be noted that limitations are associated with the use of ANOVA, LSD, and standard scores in this study, with the greatest concern being that the sample size was both small and uneven. This increases the chances of both Type I and Type II errors. Therefore, caution is warranted throughout the discussion of the results. On the other hand, the use of these tests allows for discrimination between the scores and programs that have clinically significant differences from those scores and programs that do not have such differences. Table 4.1 and Appendix G, Table G.1 indicate that an F (6, 43) value of 26.78 ($p \leq .001$) was obtained, suggesting that there was a difference in the mean scores of the risk items. The "risk items" listed as the source in Table G.1 refer to the risk behaviors of "used weapon", "used force to coerce", and so forth. The larger between-group mean square (M^2) value depicted in Appendix G, Table G.1 suggests significance in the differences between independent variables (the risk items). Appendix E, Table E.1, illustrates which risk characteristics were significantly different. Using Appendix E, Table E.1, and the standard scores, the following results are suggested. First, the use of weapons

nonconsensual peer victim, Program 2 was statistically significantly different from Program 6, Program 3 was statistically significantly different from Programs 4 and 6, and Program 5 is Level Six residential programs employ the use of weapons significantly less often than other risk characteristics. Second, inflicting statistically significantly different from Program 6. These programs are grouped together because of the direction of significance. An examination of the standard scores suggest that these programs are more likely to have a youth, as a resident, who has had at least one nonconsensual peer victim. On the other hand, Program 4 was statistically significantly different from 5 and 7, and Program 6 was statistically significantly different from Program 7. Both Programs 4 and 7 have statistically significantly fewer youth in them who have had nonconsensual peer victims than the programs against which they have been compared. Appendix G, Table G.2, demonstrates with the M^2 and subsequent F score that the programs had a significant effect on the variance.

Need Characteristics

Table 4.2 depicts the need characteristics of the youth. Need characteristics, for this research, are defined as those factors demonstrating that the offender has a need for a Level Six intervention. The Level Six sample is described by NOJOS (1996, p. 15) as often having a prior treatment history and extensive behavioral and emotional problems. One other item was added in the assessment of need by NOJOS members assisting in the construction of the JSOPPIT, "Offender cannot remain home as the victim is in the home and the offender has a history of offending in proximity to parents."

Weighted need. Weighted need, in this instance, is defined as the distance between having none of the need characteristics (0) and having all of the need characteristics (1). The differences between the weighted need scores by program were not statistically significant. Weighted need scores ranged from a low of .53 (Program 1) to a high of .80 (Program 3). The average weighted need score for the sample was .68. A graphical comparison of the program's weighted need scores, in comparison to the mean weighted need score is found in Appendix C, Figure C.2.

Table 4.2

Percentage of Offenders with Specified Need Characteristic by Program

	Program								
	1	2	3	4	5	6	7	M	
Item	n=7	n=3	n=10	n=8	n=9	n=8	n=5	N=50	F
Has documented behavioral and emotional problems that interfere with functioning in a wide variety of contexts.	86%	100%	70%	75%	100%	100%	100%	88%	.26
Standard score	-.06	.36	-.55	-.39	.36	.36	.36	0.00	
Victim is in the home and offender has history of offending in proximity to parents.	71%	67%	90%	100%	44%	88%	80%	78%	1.75
Standard score	-.22	-.34	.38	.69	-1.06	.31	.06	0.00	
Had prior history of sex offender specific treatment and has continued to offend.	29%	0%	80%	50%	67%	38%	60%	52%	1.69
Standard score	-.79	-1.79	.97	-.07	.52	-.48	.28	0.00	
F									9.64***
Weighted need	.53	.62	.80	.69	.69	.65	.75	.68	1.39
Standard score	-1.67	-.63	1.44	-.17	-.17	-.28	.86	0	

* $p \leq .05$

** $p \leq .01$

*** $p \leq .001$

Comparison of need characteristics. Table 4.2 depicts the items comprising the need characteristics, the weighted need scores, standard scores and F scores for each of the seven programs. Data analysis suggest a statistically significant difference, $F\ (2,147) = 9.64$; $p \leq .01$, between the three identified need characteristics. Appendix G, Table G.3 emphasize the difference between the characteristics with the between-groups M^2. Examination of Appendix E, Table E.4, suggests that youth presenting with a prior history of sex offender specific treatment, and having continued to offend, is statistically significantly different than the other two need characteristics. The interpretation of the analysis indicate that youth are less likely to present with this need than the other two.

Program comparisons of need characteristics. The ANOVA (Table 4.2) indicated that neither the need characteristics nor the weighted need scores were statistically significant from one another when scores across the programs were examined.

Mental Health Characteristics

Table 4.3 outlines the potential mental health diagnoses given to youth in Level Six Residential Centers. Usually, the youth were assigned these diagnoses by a licensed clinician who had more than 2,000 hr of experience with JSOs.

Comparison of mental health characteristics across the sample. In general, the diagnoses given to the youth in Level Six programs did not indicate severe psychopathology, if one defines severe as "psychotic." Disorders that are usually not treated by medication, such as paraphilias (70%), conduct disorders (42%), and features of personality disorders (46%), were by far the major mental health problems. Disorders that can be treated with psychoactive medication occurred with somewhat less frequency, namely, impulse disorder (30%), ADHD (30%), mood disorders (28%), and anxiety disorders (22%). A statistically significant F value, 15.43 (12,637; $p \leq .001$), was calculated when comparing across the differing diagnoses located in client charts. Appendix G, Table G.4 depicts the F value with its numerator (the between-group M^2 of 2.18) versus its demoninator (the within-group M^2) of .14, demonstrating that statistical differences between the

Table 4.3

Percentage of Youth with Specified DSM IV Diagnoses by Program and Standard Score

	Program								
	1	2	3	4	5	6	7	M	
Item	n=7	n=3	n=10	n=8	n=9	n=8	n=5	N=50	F
Sexual disorders	29%	67%	100%	25%	89%	75%	100%	70%	5.41***
Standard score	-.83	.17	1.04	-.94	.75	.38	1.04	0.00	
Features of personality disorders	29%	33%	40%	0%	78%	50%	100%	46%	3.89**
Standard score	-.35	-.24	-.04	-1.18	1.05	.25	1.69	0.00	
Conduct disorders	43%	25%	30%	25%	100%	50%	0%	42%	4.77***
Standard score	.28	-.28	-.13	-.28	2.06	.50	-1.07	0.00	
ADHD	14%	67%	40%	25%	22%	63%	20%	34%	1.16
Standard score	-.74	1.51	.37	-.27	-.40	1.34	-.48	0.00	
Impulse disorders	100%	67%	10%	0%	0%	63%	0%	30%	14.70***
Standard score	1.74	.92	-.50	-.74	-.74	.82	-.74	0.00	
Mood disorders	86%	44%	20%	38%	0%	38%	0%	28%	4.47**
Standard score	1.93	.53	-.28	.33	-.95	.33	-.95	0.00	
Anxiety disorders	67%	11%	10%	25%	11%	38%	0%	22%	1.77
Standard score	2.06	-.41	-.45	.21	-.41	.78	-.89	0.00	
Learning disorders	0%	33%	20%	0%	22%	38%	0%	16%	1.29
Standard score	-.88	1.17	.36	-.88	.49	1.48	-.88	0.00	
Schizophrenia/Psychosis	43%	33%	0%	13%	0%	38%	0%	16%	2.22
Standard score	1.43	.90	-.83	-.15	-.83	1.16	-.83	0.00	
Substance disorders	14%	0.37	0%	13%	22%	0%	0%	10%	.86
Standard score	.15	1.92	-.92	.08	.77	-.92	-.92	0.00	
Elimination disorders	0%	33%	10%	0%	0%	0%	0%	4%	1.62
Standard score	-.46	2.36	.40	-.46	-.46	-.46	-.46	0.00	
Mental retardation	14%	33%	0%	0%	0%	0%	0%	4%	1.81
Standard score	.68	2.26	-.49	-.49	-.49	-.49	-.49	0.00	

(table continues)

	Program								
	1	2	3	4	5	6	7	M	
Item	n=7	n=3	n=10	n=8	n=9	n=8	n=5	N=50	F
Adjustment disorders	0%	46%	0%	13%	0%	0%	0%	2%	.86
Standard score	-.45	2.38	-.45	.35	-.45	-.45	-.45	0.00	
F									15.43***

** Significant at $p \leq .01$

***Significant at $p \leq .001$

numbers of youth with the various diagnoses exist. Appendix E, Table E.5, shows where these statistically significant differences were found. Sexual disorders were diagnosed statistically significantly more often than all other disorders. Features of personality disorders were statistically significantly more likely to be diagnosed than all of the other disorders, excluding sexual disorders. Conduct disorders were statistically significantly more likely to be diagnosed than all other diagnoses, except sexual disorders and features of personality disorders. Impulse disorders were statistically significantly different from all other diagnoses, excluding sexual disorders, features of personality disorder, and conduct disorder. Findings suggest that this diagnosis was more common than the others.

Comparison of mental health characteristics by program. Statistically significant differences were found on five variables when comparing their presence across programs, namely sexual disorders, features of personality disorders, conduct disorders, impulse disorders, and mood disorders (Table 4.3). Appendix C, Figures C.3 through C.7 graphically compares the programs on these disorders. Appendix G, Table G.5 depicts the M^2s between- and within-groups on the diagnoses that were significantly different between programs, namely, sexual disorders, features of personality disorders, conduct disorders, impulse disorders, and mood disorders.

Multiple comparisons (Appendix E, Table E.6) suggest that the mean of Program 1 is statistically significantly lower than the means of Programs 3, 5, 6, and 7 on the variable "sexual disorders." The mean of Program 4 is statistically significantly lower than the mean of Programs 3,

5, 6, and 7 on the variable "sexual disorders," suggesting that youth in Program 4 are less likely to be diagnosed with a sexual disorder.

For the variable "features of personality disorders" (Appendix E, Table E.7), a statistically significant difference was noted for Programs 4 and 7 from the remaining scores. Program 4 had no offenders with personality disorders, and Program 7 diagnosed every offender as having a personality disorder. Thus, Program 4 had statistically significantly fewer personality disorders diagnosed than Programs 5, 6, and 7, whereas Program 7 had statistically significantly more personality disorders than Programs 1, 2, 4, or 6.

A statistically significant difference for the variable "conduct disorders" was found in Program 5, in which every offender was diagnosed with a conduct disorder (Appendix E, Table E.8). Program 5 had statistically significantly more conduct disorders than any of the other programs. Additionally, Program 6 had statistically significantly fewer conduct disorders than Program 5, and Program 6 had statistically significantly more conduct disorder than Program 7.

For "impulse disorders" (Appendix E, Table E.9), Program 1, 2, 6, and 7 were statistically significantly different in that there was a greater presentation of this diagnosis in these programs. Specifically, Program 1 had statistically significantly more impulse-disordered youth than Programs 3, 4, 5, 6, or 7. Program 2 had statistically significantly more impulse-disordered youth than Programs 3, 4, 5, and 7. Program 6 had statistically significantly fewer impulse disorders than Program 1, but statistically significantly more impulse disorders than Programs 3, 4, and 5. Program 7 had statistically significantly more impulse disorders than Programs 1, 2, and 6.

Finally, Program 1 was statistically different from the rest of the programs on the variable "mood disorders." Results suggest that Program 1 was more likely to have youth diagnosed with a "mood disorder" (Appendix E, Table E.10). Program 5 had statistically significantly fewer mood disorders than Programs 4 and 6.

Assessment

NOJOS (1994) specified that a Level A (line worker) assessment and either a Level B

(psycho social) or C (psychosexual) assessment were necessary to render a Level Six placement. Appendix D, Table D.1 depicts the percentage of Level A, B, and C assessments included in client charts.

Comparison of Level A, B, and/or C assessments in client charts. Only one Level A assessment (Program 2) was located during the data collection process. If Level A assessments were done, they were either not sent to the Level Six programs, or they were not included in the client's chart. Even though this was the case with Level A assessments, 97% of the clients' files contained evidence of Level B and/or Level C assessments.

Comparison of inclusion of Level A, B, and/or C Assessments by program. The F value, when comparing programs to determine if there was a statistically significant difference in the representation of these assessments in the client's chart, demonstrated no significance (Appendix D, Table D.1). The data indicate that in two programs (Programs 1 and 3), a Level B or C assessment was either missing from the chart or not appropriately signed off according to Medicaid regulations.

Type of Victimization Experiences

Table 4.4 depicts the percentage of youth who experienced some form of abuse or neglect and were not residents in the various programs.

Comparison of victimization as reported by youthful sexual offenders. Most of the youth reported to their therapist that they had been victimized in one or more of three areas examined, namely, sexually (70%), physically (68%), or through neglect (34%). Results of the ANOVA (Appendix G, Table G.6) indicate a statistically significant difference, F (2,147) = 9.23, $p \leq .001$, was noted among the types of abuse experience (sexual and physical abuse and neglect). Multiple comparison findings (Appendix E, Table E.11) suggest that neglect was statistically significantly different from both sexual and physical abuse. The data suggest the rate of neglect was somewhat less than that of sexual or physical abuse.

Table 4.4

Percentage of Offenders Victimized by Specified Form Compared by Program and Mean (M)

	Program								
	1	2	3	4	5	6	7	M	
Item	n=7	n=3	n=10	n=8	n=9	n=8	n=5	N=50	F
Sexual abuse	57%	50%	100%	100%	78%	50%	80%	70%	1.61
Standard score	-.64	-1.00	1.50	1.50	.39	-1.00	.50	0	
Physical abuse	86%	60%	67%	63%	89%	50%	60%	68%	.72
Standard score	1.36	-.62	-.10	-.42	1.61	-1.38	-.62	0	
Neglect	57%	20%	0%	25%	67%	13%	40%	34%	1.88
Standard score	.70	-.42	-1.03	-.27	.99	-.65	.18	0	
F									9.23***

*** $p \leq .001$

Comparison of victimization as reported by youthful sexual offenders by programs. No statistically significant differences were noted between programs in their representation of type of victimization as reported by the youth to their therapists.

Relationship of the Perpetrator of the Offender to the Youthful Offender

Of clinical significance is the examination of the relationship between the youthful offender and his perpetrator, if the youth has been violated. These data have significance from a risk perspective, as well as in treatment planning.

Table 4.5 illustrates the percentage of youth victimized by a specified offender, and the mean presentation of this type of victimization across the various programs. Table 4.5 shows that 64% of the youth in the programs were abused by their fathers or stepfathers, 44% were victimized by acquaintances, 26% by mothers or stepmothers, 18% by siblings, and 8% by strangers. A statistically significant difference, $F(4,245) = 13.59$, $p \leq .001$, was calculated when comparing the different offender relationships (see Appendix G, Table G.7 for data on how the F was calculated). Multiple comparisons (Appendix E, Table E.12) suggest that the category of youth

Table 4.5

Percentage of Offenders Victimized Within Specified Relationship Compared by Program and Mean (M)

	Program								
	1	2	3	4	5	6	7	M	
Item	n=7	n=3	n=10	n=8	n=9	n=8	n=5	N=50	F
Father/Stepfather	71%	40%	67%	0.63	100%	38%	80%	64%	1.96
Standard score	.37	-1.20	.13	-.08	1.80	-1.33	.80	0	
Acquaintance	29%	30%	100%	63%	44%	38%	40%	44%	1.08
Standard score	-.67	-.61	2.43	.80	.02	-.028	-.17	0	
Mother/Stepmother	29%	0%	0%	0%	67%	38%	40%	26%	3.43**
Standard score	.11	-1.08	-1.08	-1.08	1.69	.48	.58	0	
Sibling	43%	20%	0%	13%	22%	13%	0%	18%	.82
Standard score	.1.78	.14	-1.29	-.39	.30	-.39	-1.29	0	
Stranger	14%	0%	0%	13%	11%	13%	0%	8%	.38
Standard score	1.05	-1.33	-1.33	.75	.52	.75	-1.33	0	
F									13.59***

** Significant at $p \leq .01$

***Significant at $p \leq .001$

abused by their fathers/stepfathers was statistically significantly different from all of the other categories (e.g., acquaintence, mother/stepmother, and so forth) with the standard score indicating a greater number of these youth having been victimized by fathers. Victimization by an acquaintance was statistically significantly more likely to have occurred than abuse by mothers, siblings, or strangers. Finally, mothers were statistically significantly more often reported as having abused the youth than were strangers.

Comparison of the perpetrator of the offender by program. Considerable variation is seen in these figures, but Program 5 reported a statistically significant difference according to the relationship of the perpetrator to the youth. Youth in Program 5 were statistically significantly more likely to have been sexually or physically abused by their mothers/stepmothers (Appendix

E, Table E.13; Appendix G, Table G.8). Appendix C, Figure C.8, compares the programs with each other and the mean on the variable "mother/stepmother."

Offense Experiences By Sex and Age of Victim

Tables 4.6 and 4.7 depict the percentage of residents in the sample who offended against a particular gender or gender combination, and the age against which they committed their offense.

Gender of offender's victim as suggested within the sample. Table 4.6 depicts the percentage of residents offending against a particular gender or gender combination. On the average, youthful sexual offenders most frequently violated both male and female children (66%). When offenders victimized only one gender, it was most often female (24%). Only 4% of the offenders reported having violated male children. Results of the ANOVA suggest there are statistically significant differences between the gender of child victims chosen by the youthful offender, $F(2, 147) = 31.90$; $p \leq .001$ (see Appendix G, Table G.9 for data on how the F value was calculated). According to results of the LSD (Appendix E, Table E.14), which emphasizes what can be seen in the mean percentages, assaults against both female and male children were statistically significantly more often reported than against female or male children.

Comparison of gender of victims according to program. ANOVA indicates there were no differences between programs with regards to this variable (Table 4.6).

Age of offender's victim. As noted in Table 4.7, many of the offenders did not limit their assaults to children. Eighteen percent of the offenders had assaulted persons 3 or more years older than themselves, and 49% had assaulted peers. A statistically significant difference, $F(6,43) = 3.75$; $p \leq .01$, was found between programs across the variable "peer." Appendix G, Table G.10 illustrates the differences in the between- and within-groups variation in calculating the F value. According to the results of the multiple comparisons (Appendix E, Table E.15), Program 6 offenders violated peers statistically significantly less often than offenders in Programs 2, 3, 5, and 7. These findings are graphically depicted in Appendix C, Figure C.9.

Table 4.6

Percentage of Offenders Victimizing Specified Gender Compared by Program and Mean (M)

	Program								
	1	2	3	4	5	6	7	M	
Item	n=7	n=3	n=10	n=8	n=9	n=8	n=5	N=50	F
Female and male children	86%	80%	100%	50%	67%	25%	80%	66%	2.02
Standard score	.86	.61	1.48	-.70	.03	-1.78	.61	0	
Female and not male children	14%	20%	0%	50%	11%	50%	20%	52%	1.30
Standard score	-.65	-.33	-1.44	1.33	-.83	1.33	-.33	0	
Male and not female children	0%	0%	0%	0%	22%	0%	0%	4%	1.68
Standard score	-.50	-.50	-.50	-.50	2.28	-.50	-.50	0	
F									31.90***

*** Significant at $p \leq .001$

Table 4.7

Percentage of Offenders Violating Older and Peer Victims Compared by Program and Mean (M)

	Program								
	1	2	3	4	5	6	7	M	
Item	n=7	n=3	n=10	n=8	n=9	n=8	n=5	N=50	F
Person 3 or more years older	29%	10%	0%	38%	22%	0%	20%	18%	.95
Standard score	.81	-.62	-1.38	1.50	.32	-1.38	.15	0	
Peer	43%	67%	70%	13%	67%	0%	80%	49%	3.75**
Standard score	-.21	.62	.72	-1.24	.62	-1.69	1.07	0	

** Significant at $p \leq .01$

This section characterizes the relationship of the victim to the offender. It is of clinical relevance to note whom the youthful male sexual offender violates for setting standards within the residential center, and for treatment planning.

Offense Experiences by Victim Relationship

Relationship of offender to his victim in the sample. As can be seen in Table 4.8, the youth selected their victims from a combination of family, acquaintances, and strangers (64%) more often than from the remaining three categories. When examining the means of the four variables a statistically significant difference was found, $F(3,200) = 33.64$, $p \leq .001$. Appendix G, Table G. 10 compares the between- and within-group variation (M^2) of the categories of relationships of offender to his victim. Multiple comparison of the means suggest that the variable "combination of family, acquaintances, and strangers" differed statistically significantly from every other group (Appendix E, Table E.16). The data show that statistically significantly more of the offenders victimized a combination of family, acquaintances, and strangers. The variable "family only" also differed significantly from every other group. The data show that the offenders victimized family only statistically significantly less often than a combination of family, acquaintances and strangers, and statistically significantly more than only acquaintances or only strangers.

Comparison of the relationship of offender to his victim by program. As illustrated in Table 4.8, a statistically significant difference, $F(6,43) = 3.37$, $p \leq .01$, was noted between the seven programs for the variable, "combination family, acquaintances, and strangers." Appendix G, Table G.12 shows how the data used in calculating the F value. Multiple comparison (Appendix E, Table E.16) would suggest that Program 6 was statistically significantly different from the other six programs in that it was least likely to have had offenders reporting this victim orientation profile. Appendix C, Figure C.10, graphically compares the programs on the variable "combination of family, acquaintances, and strangers."

Table 4.8

Relationship of Offender to His Victim Compared by Program and Mean (M)

	Program								
Item	1 n=7	2 n=3	3 n=10	4 n=8	5 n=9	6 n=8	7 n=5	M N=50	F
Combination family, acquaintances, and strangers	86%	70%	100%	50%	67%	13%	100%	64%	3.37**
Standard score	.75	.21	1.24	-.48	.09	-1.78	1.24	0.00	
Family members only	14%	20%	0%	50%	22%	63%	0%	28%	1.99
Standard score	-.45	-.18	-1.09	1.18	-.09	1.77	-1.09	0.00	
Acquaintances only	0%	10%	0%	0%	11%	13%	0%	10%	.43
Standard score	-.67	1.00	-.67	-.67	1.17	1.15	-.67	0.00	
Strangers only	0%	0%	0%	0%	0%	0%	0%	0%	0.00
Standard score	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
F									33.64***

** Significant at $p \leq .01$

*** Significant at $p \leq .001$

Treatment/Placement Experiences in Other Residential Facilities

Appendix D, Table D.2, shows the percentage of youth in each of the programs who had one, two, or three or more placements prior to their current placement. A final category, "one or more placements," was added to call attention to the number of youth who had extra placement experiences in other JSO-specific residential programs.

Number of treatment/placement experiences for the youth as reported by the therapist to the evaluator. An ANOVA was performed on the variables "one," "two," and "three or more." The offenders were statistically significantly more likely, F (2,147) = 5.42; $p \leq .01$, to have been in only one other JSO residential placement (26%) prior to their current placement (Appendix E, Table E.16). When summing across the total number of placements, it was determined that 42% of the youth had had at least one or more placements prior to the present placement (Appendix D, Table D.2).

Treatment/placement experiences in the programs. ANOVA results suggest that when comparing programs, only one of the items was found to be statistically significantly different, namely, having three or more placements, F (6,43) = 5.05; $p \leq 001$ (Appendix E, Table E.17). To ascertain which programs were statistically significantly different, multiple comparisons were calculated (Appendix E, Table E.18). These results indicate that Program 5 was statistically significantly different from Programs 1, 2, 3, 4, 6, and 7. Program 5 had more youth in their custody (56%) who had three or more placements prior to coming into this program than did the other programs. Appendix C, Figure C.11, compares across the programs on the variable "three or more placements."

Average treatment/ placement experiences. Appendix D, Table D.3, shows the average treatment/placement experiences that were self-reported by youth. The average number of: (a) residential treatment/placements in JSO-specific programs, (b) different outpatient episodes, and (c) months in their current placement were examined. Data presented in Appendix D, Table D.3, represent the average number of placements youths had prior to the current placement. For example, Program 1 shows that the seven youth, on the average, had .3 JSO placements prior to admittance into Program 1. Some youth may have had three or more placements whereas others had none. This average helps one understand which program had youth admitted who had already been through other sex offending programs. The average number of placements in other juvenile offender specific facilities for the sample was .5. The average number of outpatient episodes was also .5. Finally, the average number of months a youth had been in their current placement, for this sample, was 14, with a range from 9 to 20. Results of the ANOVA show no statistically significant differences between the programs.

Average treatment/placement experiences across the programs. According to the results of the ANOVA, there were no statistically significant differences across programs when examining treatment/placement experiences of the youth in the various programs.

Intake Criteria and Procedures

Intake criteria refer to eligibility requirements necessary to accept a youth into a Level Six program. Intake procedures describe the protocol that is used to establish a youth as a resident. Two sources of information were used for this portion of the instrument. Clinical files provided the data source for intake criteria. Program written materials and the verbal responses of the program representative provided the data for intake procedures.

Intake Criteria Implementation

DHS licensing (1991) has stipulated that written documentation of criteria including age and gender of the offender, specification of program needs and services the program is designed to deliver, and the program's limitations relative to a youth are expected. The items measuring intake criteria were chosen by the Western Region Family Services (1996) and include the criteria specified by DHS. The seven intake criteria include: (a) gender of youth, (b) range of ages that the program serves, (c) DSM IV categories the programs are not designed to treat, (d) cognitive capabilities of youth who are not acceptable for admission, (e) level of parental and/or community support required for acceptance into the program, (f) judicial and legal requirements for admission into the program, and (g) nonsexual criminal or antisocial behaviors that do not stop admission, such as fire setting, assault, and so forth. The information for each program was taken from intake manuals and brochures of the program.

Results of the evaluation indicated that Programs 3 and 5 included information meeting two of seven criteria. Program 3 included the gender of youth and the ranges of ages that the program served, whereas Program 5 included range of ages that the program served and the level of parental/and or community support required for acceptance into the program. Programs 6 and 7 each included one of the seven criteria. Program 6 included nonsexual criminal or antisocial behaviors that do not stop admission such as fire setting, assault, and so forth and Program 7

included the range of ages the program served. It was concluded that no program included all seven criteria, and only those identified above included any of them in their intake procedures.

Intake Procedures

The Western Region DCFS (1996) proposed that intake procedures be written. The DHS Contract specifies that programs shall have persons who are responsible for coordinating intake and that parents and youths be given written copies of the program's procedures and goals. Three items were used to measure "good practice" intake procedures: (a) written intake procedure, (b) written copies of program procedures and goals available to give youths and parents/guardians, and (c) intake coordinator or person responsible for coordinating intake. An implementation index was derived and an implementation score of .91 was calculated. This score suggests that programs were in compliance, for the most part, with "good practice" standards. Exceptions to these findings were with Programs 4 and 6, which had no written documentation of their intake procedures.

Treatment Constellation

Treatment constellation refers to the process of treatment planning. Three sources of information were used to examine treatment constellation. The first source of information was client files. This data set, consisting of the largest data pool (n = 50), examined (a) treatment goals, (b) whether there were signed treatment/skills development plan, (c) whether there was compliance with medicaid treatment planning procedures, and (d) treatment modalities implemented. The second source of information was interviews with residents and line workers. These data addressed understanding of treatment goals. Not all of youthful male sexual offenders were available during the time of interview; thus the interview data pool was somewhat smaller (n = 47) than the number of case files examined. Finally, information regarding treatment modalities was gleaned from treatment manuals at each program site (n=1 for each program, total N =7).

Understanding of Treatment Goals

Understanding treatment goals is a critical aspect of therapy, both for the youth, and for the line and clinical staff. It is suggested that two sources of data help one ascertain the degree of understanding of treatment goals. The most obvious is whether the youth signed a treatment plan. It would be logical to assume, though not necessarily true, that youth would read and perhaps discuss their treatment plan prior to signing the agreement, especially since the agreement impacts their progress and length of residence. Next, one would assume that if youth and staff could express the treatment plan with words, describe the goals, and identify sex offender specific categories (e.g., cognitive distortions, reducing deviant arousal, and so forth) important to the therapy process, that this would be an indicator of understanding.

Signing of treatment plans. Appendix D, Table D.4, indicates that 45% of the youth had signed a mental health and skills development treatment plan. Mental health treatment plans focus on issues surrounding the youth's psychiatric diagnosis(es). Skills development treatment plans involve issues of personal and interpersonal competency (e.g., education, dating behavior, hygiene, and so forth). In all cases, mental health and skills development treatment plans were combined into the same document, with goals specifically addressing mental health and skills development.

Signing of treatment plans by program. It is interesting to note that Programs 3 and 5 had every youth sign their treatment plan, whereas Programs 6 and 7 had no youth signing them. The reason for this difference is unknown.

Youth's average listing of treatment content, goals, and categories. Three items assessed the youths' understanding of their treatment plan. First, the youths' understanding of the *content* of their treatment plans was measured by counting the number of matches between the words selected by the youth in describing their treatment plans and a list of treatment words used in JSO therapy. These words were organized into seven categories: decreasing cognitive distortions, reducing deviant arousal, relapse prevention, healing personal victimization, increasing personal competency, increasing interpersonal competency, and decreasing exploitative behavior. Next, the

youths' understanding of the *depth* of their treatment plan was measured by the number of separate treatment goals listed by the youth. Finally, the *breadth* of the youths' understanding of treatment goals was measured by counting the number of treatment categories that were subsumed in the treatment words identified by the youth. It should be noted that differences may have occurred as a result of how long the youth had been in the treatment facility. These data, therefore, must be viewed with caution, and further research should examine these areas for factors such as length of time in the residence and previous residential center experience.

Appendix D, Table D.5, lists the average number of responses provided by the youth for each of the three items. In regards to the content aspect of the youths' understanding of their treatment plan, it was determined that the youth, on the average, listed eight words that matched the experts' list. The greatest average was 13, and the low was 6. The pool consisted of more than 300 words. Of interest is the number of matches by the one youth in Program 2 (13) when contrasted with other programs.

In examining the depth of understanding, the findings suggest youth could identify, on the average, four treatment goals. It is not clear how many treatment goals were possible. This is an area of focus for future research and may make a difference in ascertaining depth of understanding if this remains the item selected for this purpose.

On average, the youth used terms during the interview that were associated with three categories that described their treatment goals. The number of categories identified by the youth suggests the breadth of their understanding of their treatment goals. The findings suggest that youth identified, on average, three of seven treatment categories.

Line workers' average listing of treatment content, goals, and categories. Line workers' average understanding of the content (number of words), depth (number of goals), and breadth (number of categories) of the youths' treatment plans was measured in a manner identical to the method employed to assess the youths' understanding.

Appendix D, Table D.6, depicts line staff understanding of the content of the youths' treatment plan. The data indicate that line staff could identify, on average, 4.86 words that were consistent with the list provided by the pool of experts. This is an extremely low number of words when compared with the list of approximately 300.

Ascertaining the depth of understanding, the line workers could describe approximately 2.57 goals in the treatment plans. It is difficult to determine if this truly gives one an understanding of their comprehension of the "depth" of knowledge considering that it is unknown how many goals were possible--which may have varied by case.

Finally, the data regarding the breadth of knowledge of line workers relative to the treatment plans suggest they could list 2.57 of the possible 7 categories that would be included in the treatment plans. It is curious to see that the youth, on the average, listed three more treatment words, two more treatment goals, and one more treatment category than the line workers.

Youth versus line staff understanding of the treatment plan. It seems appropriate to ascertain the degree of understanding that youth have about their treatment plan in comparison with the staff they are in daily interaction with. Therefore, these data draw from Appendix D, Tables D.5 and D.6. In terms of content, youth used 8.57 words from the pool created by experts, whereas line staff utilized 4.86. It is interesting to note that the youth described their treatment plan with about twice as many words than did line staff. In terms of depth, youth could describe 3.57 goals and line staff 2.57. Whereas the youth seemed to know more about their treatment goals than line staff, it was by only one goal. An examination of the breadth, comparatively, demonstrates that youth presented 3.0 categories whereas the line staff expressed 2.57. The greatest discrepancy appeared to be in the area of content.

Again, caution is warranted. It is not known the length of time line staff were employed or the differences in education with regards to, for example, words associated with sexually offensive behavior and treatment.

Treatment goal categories included in client files. Table 4.9 shows the percentages of treatment goal categories included in the youths' charts by program and an implementation index suggesting the relative success in describing these goals. An F of 30.92 (6, 43; $p \leq .001$) was obtained when comparing the seven treatment goals, suggesting a statistically significant difference existing between these goals (see ANOVA data in Appendix G, Table G.13). Appendix E, Table E.19, provides multiple comparison data that help clarify the nature of the differences. Remediating cognitive distortions occurred more frequently in the treatment goals than reducing deviant arousal, relapse prevention, healing personal victimization, or decreasing exploitative behavior. Increasing interpersonal competency, a frequent skills development goal, occurred statistically significantly more often than reducing deviant arousal, relapse prevention, increasing personal competency, or decreasing exploitative behavior. Healing personal victimization occurred statistically significantly less than reducing deviant arousal, relapse prevention, healing personal victimization, and decreasing exploitative behavior.

Comparison of treatment goals included in client files by program. Results of the ANOVA (Table 4.9) suggest that four treatment goals were differentially applied by the various programs at a statistically significant level. Appendix G, Table G.14 shows the variation between the between- and within-group means in calculating the F values. By using the LSD (Appendix E, Table E.20) to examine statistically significant F scores, it was noted that reducing deviant arousal occurred less frequently in Program 2 than Programs 1, 3, 4, 6, and 7. In fact, Program 2 did not have a single indicator of this treatment goal being included in the youths' treatment regimen. It also occurred statistically significantly less often in Program 5 than in Programs 3, 4, 6 , and 7. Relapse prevention occurred less frequently in Programs 1, 2, and 6 than in Programs 3, 4, 5, and 7 (Appendix E, Table E.20). Increasing personal competency was less frequent in Program 1 than in Programs 2, 3, 4, 6, and 7 (Appendix E, Table E.22). Increasing personal competency was statistically significantly less often reported in Program 5 than in all other programs. Decreasing exploitative behaviors was identified statistically significantly more often as a treatment goal in

Table 4.9

Percentage of Client Files with Treatment Goals in Each Category Compared by Program and Mean (M)

	Program								
	1	2	3	4	5	6	7	M	
Item	n=7	n=3	n=10	n=8	n=9	n=8	n=5	N=50	F
Remediating cognitive distortions	100%	100%	80%	100%	100%	63%	100%	90%	2.11
Standard score	.53	.53	-.8	.53	.53	-1.93	.53	0	
Reducing deviant arousal	86%	0%	100%	75%	22%	75%	100%	65%	6.74***
Standard score	.58	-1.81	.97	.28	-1.19	.28	.97	0	
Relapse prevention	29%	0%	100%	100%	89%	25%	100%	63%	12.26***
Standard score	-.86	-1.58	.93	.93	.65	-.95	.93	0	
Healing personal victimization	0%	0%	0%	13%	0%	0%	0%	2%	.86
Standard score	-.05	-.05	-.05	2.63	-.05	-.05	-.05	0.00	
Increasing interpersonal competency	86%	100%	100%	100%	78%	100%	100%	95%	1.21
Standard score	-1.03	.56	.56	.56	-1.91	.56	.56	0.00	
Increasing personal competency	43%	100%	80%	100%	11%	100%	100%	76%	10.02***
Standard score	-1.00	.73	.12	.73	-1.97	.73	.73	0.00	
Decreasing exploitative behaviors	29%	0%	100%	86%	88%	29%	40%	53%	5.80***
Standard score	-.70	-1.51	1.34	.93	.99	-.70	-.37	0.00	
F									30.92***
Implementation index	.53	.43	.80	.84	.54	.55	.77	.64	1.02
Standard score	-.73	-1.4	1.07	1.33	-.67	-.60	.87	0.00	

* Significant at $p \leq .05$

** Significant at $p \leq .01$

***Significant at $p \leq .001$

Program 3 than in Programs 1, 2, and 6 (Appendix E, Table E.23). It also occurred statistically significantly more frequently in Programs 4 and 5 than in Programs 1, 2, 6, and 7.

Appendix C, Figures C.12 through C.15, shows differences in treatment goal implementation across the programs and compares these differences to the mean for all programs.

Medicaid planning procedures in the population. Appendix D, Table D.7, shows that Level Six residential programs differ in their level of compliance to Medicaid treatment planning procedures, F (6,43) = 5.23; $p \leq .001$. The multiple comparison suggests that differences are noted in Program 2, which is less compliant with these regulations than the remaining programs. Caution should be taken, however, in that $n = 3$, and the client charts in Program 2 were missing only one signature.

Medicaid planning procedures by program. There were statistically significant differences between the programs on the variables "skills development plan was signed. . .," F (6,43) = 3.18; $p \leq .05$, and "skills development plan contained the credentials. . .," F (6,43) = 3.18; $p \leq .05$. With regards to the first item, "skills development plan was signed. . .," in Program 2, 67% had signed a skills development plan, whereas 90% of Program 3 had signed (Appendix E, Table E.24). It should be noted, however, that Programs 2 and 3 each had one chart that lacked a signature and credentials. Because Program 2 had a sample of only three, the lack of one signature put their compliance at .67. Program 3 had a sample of 10, so the lack of one signature put their compliance at .90. It is important that these findings not be overinterpreted, which is logical when one considers the "n" for these programs.

When examining the item "skills development plan contained the credentials. . .," the results suggest that Programs 2 and 3, as noted previously, lacked signatures by those who had the appropriate credentials (see Appendix E, Table E.25). As mentioned, caution in interpretation is warranted.

Percentage of programs with master therapy manual across population and programs. This item was borrowed from the Western Region DCFS (1996) study, which asked its participating programs whether they had a master therapy manual. All of the programs in the present study had some type of manual describing their therapeutic protocol.

Inclusion of family therapy in the treatment protocol. Two items regarding family therapy were also borrowed from the Western Region DCFS study: (a) Do the client files include family therapy as part of the treatment plan, unless it is documented that the family is unavailable or unwilling to participate in treatment, and (b) are the family therapy sessions JSO specific? The first question required locating the information in the individual client files. All of the programs fully complied, except for Program 1, in which two of the seven offenders did not meet the requirement. The second question involved inquiring about the content of family therapy. If the program representative stated that family therapy sessions addressed items pertinent to youthful sex offending, the program's response to the question was marked affirmative. All programs met this requirement.

Compliance with quarterly summary reports. The DHS contract specifies that quarterly progress reports be sent, and documented being sent, to case managers within 30 days of the end of the quarter. Although some programs did not document their sending of the quarterly summary, most reported that they had sent the quarterly summary. For inclusion as having been sent, the documentation of its being sent needed to be included in the file. Appendix D, Table D.8, shows that there was, on the average, a 61% compliance rate, with a range of 0% (Program 2) to 100 % (Programs 3, 5, and 7). A statistically significant difference was demonstrated , F (6,43) = 9.70; $p \leq .001$. Multiple comparison suggests that the differences were as follows: Program 2 complied statistically significantly less than Programs 1, 3, 5, or 7 (Appendix E, Table E.26) in providing DHS with a quarterly summary. Programs 3, 5, and 7 complied statistically significantly more than 2, 4, or 6, and Program 1 complied statistically significantly more than Programs 2 and

4. Appendix C, Figure C.16 compares the programs in their compliance with documenting the sending of the quarterly summary report.

Group therapy utilization and documentation. Three items measured implementation of group therapy (Appendix D, Table D.8): (a) Is group therapy noted in progress notes with the date and time spent?, (b) Is the number of clients in the session documented in the progress notes?, and (c) Is the progress on treatment goals during group session noted by the key words from the treatment plan? Medicaid requirements necessitate that these items be documented in client files.

Results of the data indicate that all programs were compliant with documentation of items "a" and "c." This was not the case, however, for item "b." Only Programs 1 and 2 documented the number of clients included in the session in the progress notes. The remaining programs did not have evidence of such documentation.

Specific content areas for inclusion in group therapy sessions. NOJOS (1996), the DHS contract, and Western Region DCFS (1996) outlined several content areas for group therapy that were included in the inventory. Most of these content areas had 100% compliance, including (a) group therapy twice a week, (b) sexual assault cycle work, (c) relapse prevention plan, (d) AIDS education, and (e) training about sexually transmitted diseases. One item, however, was neglected by Programs 2 and 5: the use of behavioral strategies to help reduce deviant arousal. This may be accounted for by their treatment program philosophy which tends to be more cognitively than behaviorally oriented.

Documentation of individual therapy requirements. With regards to individual therapy, Medicaid requires that: (a) individual progress notes document date and time spent, (b) key words from the treatment plan be utilized in progress notes, (c) individual therapy occur at least two times weekly, and (d) individual therapy serve as an adjunct to group therapy. In terms of "a," "b," and "d" of the above, it was noted that all of the programs complied with these requirements. There was only one exception in terms of the number of individual therapy session occurring

weekly. Data from Program 6 indicated that although there was individual therapy, it did not occur two times per week.

Adjunctive therapy compliance. Adjunctive therapies are those interventive strategies that support the basic therapeutic modality of the programs for remediating sexually abusive behavior, but at the same time may not be sex-offending specific; for example, psychopharmacological therapy, occupational therapy, and so forth. The results suggest 100% compliance with the provision of adjunctive therapies.

Skills development services (SDS) compliance of the population and across the programs. Guidelines provided by NOJOS (1996) and the DHS contract require skills development services, namely, that: (a) life skills training/day treatment should occur at least 3 hr per day, (b) the training should focus on mastering social skills peculiar to the target population and include those associated with traditional independent living contexts, and (c) documentation of SDS should include a daily entry including date, number of hours of service, and a brief description of the service in the clients' files. Findings indicate that programs were 100% in compliance with skills training guidelines.

Recreational activities compliance. As with skills development services, NOJOS (1996) and the DHS contract provide guidelines specifying that recreational activities should occur at least two times per week, and that such activities be planned in advance. The programs were 100% in compliance with these guidelines.

Educational placement in the population and across the programs. The NOJOS committee assisting the researcher in constructing the inventory requested information on the educational placement of the youth in Level Six programs. All 50 youth from the population were involved in an accredited Youth-in-Custody educational placement.

Staffing compliance. Department of Human Services licensing requires that client staffings be held weekly. All programs were in compliance with this requirement.

Supervision

Supervision refers to the degree of physical control exercised over the offender. It includes the type of custody arrangement, staff control of youth, the degree of control offered by the physical environment, monitoring systems, and behavior management. All of the youth examined were in the custody of the State of Utah, so type of custody arrangement will not be discussed here.

Staff Supervision of Youth

Staff supervision of youth was assessed by compliance with two items from the DHS Contract: (a) the program maintains a 24 hr/day awake supervision protocol, and (b) the program provides a 1:3 staff to client ratio during day hours. All the programs complied with both requirements.

Physical Environment as a Supervision Modality

The question used to assess the degree of supervision that could be attributed to how the physical environment had been organized was, "To what extent does the facility meet the specified guidelines for supervisory purposes?" Thirteen items addressed this question (Appendix A). Programs complied with all items with the exception of Programs 1 and 3. Program 1 did not provide "one toilet, one lavatory, one tub or shower for each six residents" and Program 3 did not have "at least 60 square feet per occupant in the bedrooms."

The DHS requires monitoring of the youth because the residential centers are not "lock-down" facilities. Residential facilities house youth who have violated the law and need constant monitoring. Three methods of monitoring were examined in this study, namely, monitoring by means of electronic sensing devices, use of self-contained schools, and staff monitoring throughout the night. Four of the seven programs had some form of electronic monitoring systems (Programs 4, 5, 6, and 7). All of the facilities, with the exception of Program 4, had a self-contained educational system. Program 4 compensated for the lack of a self-contained

educational system by having staff members attend to the offenders' classroom at the local school. Finally, all of the programs were in compliance with night time monitoring of the residents.

Behavioral Management Policy and Procedures

The assessment of the behavioral management policy and procedures necessitated an examination of program materials describing their policies and procedures with regards to: (a) behavioral management system, (b) program rules, (c) description of the process employed when violations of rules occur by resident, (d) grievance procedures, (e) termination as a consequence for severe misconduct, and (e) control of behavior during home visits.

In order to assess behavioral management policy and procedure, it was necessary that programs have a manual outlining these policies and procedures. Such a manual is suggested by the Western Region Division of Child and Family Services (1996), but not required. It is encouraging to note that all programs had a policy and procedures manual to refer to for behavioral management issues.

Behavioral management system. A behavioral management system defines inappropriate behavior and describes staff responses to such behavior. Data indicate that all of the programs had a written behavioral management system that addressed each of the items discussed in the JSOPPIT.

Adequacy of program practices designed to protect youth in the program. Seven practice guidelines were identified by the Western Region DCFS (1996). These guidelines examine levels at the time the youth enter and exit various levels, progress in the program, rules about various behaviors, and so forth. A review of the data indicates that Program 6 did not have written rules about bedroom and bathroom behaviors or room assignment. Programs 4 and 5 specify rules regarding bathroom behavior or practices governing room assignment. Programs 1, 2, and 3 did not have a written procedure regarding room assignment.

Average number of matches between line staffs' identification of rules regarding bedroom, bathroom, and interpersonal behaviors of residential youth and written rules. Appendix

D, Table D.9, depicts the average number of rules identified by the line staff with regards to bedroom, bathroom, and interpersonal behavior. Numbers represent the frequency of matches between the line staffs' response during the interview and the program's list of rules (hereafter referred to as "written rules"). Line staff identified an average of 1.00 bedroom rule (SD = .53), .14 bathroom rules (SD = .35), and 1.43 interpersonal rules (SD = .32).

The responses of the line staff were not controlled for length of employment, the number of rules a program had at the time of the evaluation, or any other variables that might affect the number or rules listed. Thus, the results of the line staffs' responses to the question, "Please list one or two rules that you feel are important for youth to follow (in the bedroom, in the bathroom, in order to get along)," must not be overinterpreted.

Average number of matches between youths' identification of rules associated with their bedroom, bathroom and interpersonal behavior compared with the responses provided by the program, line staff, and peers. I was interested in ascertaining differences between means of communicating rules: (a) through writing, (b) through the teaching of line staff, or (c) through the peer network. To examine this question, the verbal responses of the youth were compared with written rules, verbal responses of the line staff, and verbal responses of other peers. Appendix C, Figure C.17, illustrates the differences between the programs and the types of communication of rules. As can be seen from Appendix C, Figure C.17, the most effective dissemination of rules came through the peer culture. With the exception of Programs 2 and 6, communication of rules between peers seemed to be more effective. In Program 2 there were no youth with which to compare. In Program 6, both the written rules (1.29) and communication between peers (1.14) were similarly effective.

As previously stated, factors that may have affected the number of rules identified may have inflated or deflated the frequency of matches. It is important, thus, that the results be viewed with caution.

Table 4.10 depicts the average number of bedroom rules verbalized by the youth and matched with written, line staff-listed, and peer-listed rules. The youth matched an average of ..67 written and line staff-listed rules. The youth matched an average of 2.17 peer-listed rules. The greater number of peer-listed matches was not significant.

Table 4.11 depicts the average number of bathroom rules verbalized by the youth and matched with written, line staff-listed, and peer-listed rules. The youth had an overall match rate of .28 per youth with written program rules about the bathroom, 1.22 matches between their responses and that of the line staff, and an average match rate of 3.50 with their peers. Appendix C, Figure C.18, depicts the differences between the programs and the modes of communication regarding bathroom rules. As was the case with bedroom rules, the most powerful source of rule communication appeared to be peer-to-peer.

Of particular interest was the finding that Programs 1, 2, and 7 had no matches between youth descriptions of the bathroom rules and those that were written (Appendix D, Table D.9). Of concern was the fact that Program 7 had no bathroom rules against which matches could have been made. With regards to rules associated with the bathroom, there were more matches with the staff listing of the bathroom rules than with those communicated through writing; however, peers again became the primary source of information. As with bedroom rules, Program 6 was the exception; however, it should be noted that this program did have rules.

Table 4.12 compares the number of matches youth made with those listed by the program, line staff, and their peers with regards to interpersonal behavior. Youth matched an overall average of 1.37 written rules, 1.17 rules communicated by line staff, and 2.78 rules communicated by peers. Appendix C, Figure C.19 graphically depicts these particular matching categories. In all cases, except Program 2, the youths had the most matches with their peers. In Programs 4, 5, and 6, written communication was the next most powerful mode of transmitting rules. Program 4 had no matches on interpersonal rules between the youths and line staff. Data

Table 4.10

Average Number of Matches Between Youths' Response and Written Rules and Line Staff-Listed, and Peer-Listed Rules About Bedroom Behaviors

	Program								
	1	2	3	4	5	6	7	M	
Item	n=7	n=1	n=10	n=8	n=7	n=8	n=6	N=47	SD
Written bedroom rules	.86	2	.90	.43	1	1.29	.29	.67	1.02
Standard score	-.35	2.09	-.25	-1.25	-.04	.57	-.75	0	
Line staff- listed rules	.57	2	.60	.29	.29	.29	.67	.67	.56
Standard score	-.18	2.36	-.13	-.68	-.68	-.68	0	0	
Peer- listed rules	2.29	0.00	3.80	1.14	4.00	1.14	2.83	2.17	1.38
Standard score	.87	-1.57	1.18	-.75	1.33	-.75	.48	0	

Table 4.11

Average Number of Matches Between Youths' Response and Written Rules and Line Staff-Listed, and Peer-Listed Rules About Bathroom Behaviors

	Program								
	1	2	3	4	5	6	7	M	
Item	n=7	n=1	n=10	n=8	n=7	n=8	n=6	N=47	SD
Written rules	0.00	0.00	.40	.14	.14	1.29	0.00	.28	.43
Standard score	-.65	-.65	.27	-.32	-.32	2.33	-.65	0.00	
Line staff-listed rules	1.00	2.00	1.30	.71	1.57	1.14	.83	1.22	.41
Standard score	-.54	1.88	.19	-1.23	.84	-.19	-.94	0.00	
Peer listed- rules	4.14	0	5.40	3.71	4.29	4.29	2.67	3.50	1.61
Standard score	.40	-2.17	1.18	.13	.49	.49	-.52	0	

Table 4.12

Average Number of Matches Between Youths' Response and Written Rules and Line Staff-Listed, and Peer-Listed Rules About Interpersonal Behaviors

	Program								
Item	1 n=7	2 n=1	3 n=10	4 n=8	5 n=7	6 n=8	7 n=6	M N=47	SD
Written rules	.67	2.00	.60	1.71	1.29	2.14	1.17	1.37	.57
Standard score	-1.24	1.11	-1.36	.61	-.15	1.37	-.36	0.00	
Line staff listed-rules	.86	4.00	.80	0.00	1.14	.86	.50	1.17	1.20
Standard score	-.26	2.35	-.30	-.96	-.02	-.25	-.55	0.00	
Peer-listed -rules	2.00	0.00	4.50	4.86	2.43	3.14	2.50	2.78	1.51
Standard score	-.52	-1.85	1.14	1.38	-.23	.24	-.18	0.00	

comparing Programs 1, 2, 3, and 7 demonstrate that line staff matches were more frequent than those with written rules.

Description of the process employed when violations of rules occur by resident. The violation process refers to those policies and procedures regarding actions taken when program rules are violated. Seven items were used to measure the adequacy of the violation process (Appendix A). Programs 3 and 4 did not have a written policy regarding how violations were to be determined to have actually occurred, whereas Program 5 did not have a written grievance procedure in place for youth and parents. Outside of these two exceptions, there was complete compliance with the DHS contract and other specified guidelines.

Supervision of youth during home visits. Programs enforce supervision of youth when they are in home-visit situations by mandating that parents understand the requirements associated with the home visit and training the parents in supervision techniques. This is an excellent method of mainstreaming and creates an environment of accountability for the

youth by their parent(s) and/or guardian. Data resulting from the evaluation indicate compliance with these requirements.

Aftercare

Aftercare refers to the continued treatment and supervision of a JSO following release from a residential program. The network of services available to the youth following his discharge is sometimes referred to as the "continuum of care."

Availability, Modalities, and Duration of Aftercare

The question guiding this section is, "To what extent are the programs capable of providing a continuum of care, aftercare, for residents in their program?" Nine items were used to assess aftercare potential. Four items addressed availability of aftercare settings, four addressed modalities, and one addressed the duration of aftercare (Appendix A).

Program 4 appeared to have the least availability of adequate aftercare services. Program 4 could not provide or arrange for therapy for a youth in the custody of the state outside of living at home or being placed in other community programs. Program 4 did not have Level Three or Four JSO specific treatment available within their own or an allied agency.

In terms of modalities offered in aftercare settings, Programs 1, 2, and 4 used individual rather than group therapy as the primary mode of treatment in aftercare. It has been recommended that aftercare maintain a strong and focused group orientation as opposed to individual therapy. Individual therapy is perceived as an adjunct to group therapy.

The offenders' aftercare did not extend at least 6 months following release. Two discrepancies were noted in other programs. Programs 1 and 2 did not use group therapy as the primary mode of treatment. Program 3 did not have aftercare services extend at least 6 months after the offenders' release.

Adequacy of Documentation of Aftercare Services

Four items were used to assess if aftercare services were adequately documented. These items ascertained if the program (a) maintained a copy of the youth's aftercare plan, (b) documented aftercare services in the client's individual file, (c) attached a copy of the aftercare plan to the discharge summary, and (d) collaborated with DCFS in constructing the aftercare plan. Four of the programs were in 100% compliance. Programs 1 and 2 did not have their aftercare plans in the individual client files, and Program 3 did not have the aftercare plan attached to the discharge summary.

Tracking Recidivism

Efforts to track sexual and nonsexual recidivism in the programs ranged from " word of mouth" to a formal survey procedure. Three programs (1, 2, and 7) made an effort to track recidivism in some form, but only one of the three, Program 1, used a formal tracking method.

Staff Qualifications and Training

Sex abuse treatment workers, both clinicians and line staff, must prove accountable both legally and professionally. Legal accountability requires that workers must pass a background check with the Bureau of Criminal Investigations (BCI). Further, their names must be checked with the child abuse registry, known formally as a Utah Social Services Delivery System Child Protective Services (USSDS) to ascertain if their names appear. Professionally, therapists must have adequate licensure, experience, and supervision. Line staff must have adequate training. Both therapists and line staff must sign a code of conduct prior to hiring. The information regarding legal and professional accountability was taken from the therapists' and line staffs' personnel files.

Legal Accountability

DHS licensing (1991) requires that programs maintain a BCI and USSDS background check in their personnel file. Western Region DCFS (1996) suggests that the background check be updated yearly. Programs 1, 2, 4, and 6 kept BCI and USSDS background checks updated yearly. Programs 3, 6, and 7 had BCI and USSDS background checks in their files, but did not update them yearly.

Professional Accountability

Therapists. The DHS contract specifies that programs maintain a record of the therapists' clinical experience working with JSOs. Programs 3 and 4 did not keep documentation of the therapists' clinical experience, but rather depended on the therapists to maintain their own documentation. All of the personnel files in the programs contained copies of the therapists' licensure as well as a signed code of conduct.

Line staff. In order to be hired as a line staff, one is required by DHS contract to have at least 20 hr of preservice training, plus 2 hr of basic first aid and CPR training. All of the programs met this requirement. Additionally, the programs maintained documentation of the training received by line staff. Finally, all of the personnel files of the line staff contained signed codes of conduct.

After one is hired, further training is required. Appendix A lists 12 subjects that are required by the DHS contract to be part of the line staff's training. Only Programs 1 and 2 were in compliance with training requirements established by the DHS Contract. Programs 3, 4, and 5 did not have a line staff member trained on court procedures. Programs 3, 4, and 6 did not have a line staff member trained on applicable federal entitlements. Programs 3 and 7 did not have a person trained on the provider's contract.

CHAPTER 5

DISCUSSION

Statement of the Problem

With the increasing numbers of JSOs adjudicated each year (Freeman-Longo et al., 1994), society has demanded that intervention be legislated to protect against further violation. In response to legislative efforts, an increasing number of treatment facilities, outpatient, inpatient, residential, and lock-down, have evolved. Unfortunately, reports suggest that the recidivism rates of youthful male sexual offenders remain significantly high (Openshaw & Barlow, 1997). Efforts to examine the effectiveness of programs designed to remediate perpetrating behavior have been minimal, with the most recent attempt being that initiated by the Western DCFS (1996). One reason for such neglect in this area has been the focus on adult male sexual offenders, implying that youthful male sexual offenders are not as significant a problem. Yet data suggest that it is during pre- and adolescent periods of life that this behavior becomes ingrained and focused (Graves, 1993). Thus, efforts to understand how to more effectively deal with youthful sexual offenders are of critical importance.

This research builds on the efforts of the Western Region DCFS, and builds into the study the requirements of Medicaid, DHS licensing (1991), the DHS contract, and the suggestions of NOJOS. Consequent to the concerns with recidivism, this study was designed to investigate whether programs delivering services to youthful male sexual offenders were implementing recommendations provided by state and local agencies. This study does not address recidivism, but specifically examines implementation of contract and recommended guidelines suggested as critical to providing effective and efficient treatment for these youth.

This research is seminal in that there is no evidence of such research having previously been undertaken in as comprehensive a manner. This research, therefore, had two objectives. **First** was the designing and testing of an instrument that incorporated the specific contract

guidelines provided by the state, with recommendations from recognized agencies participating in developing treatment protocols (e.g., NOJOS). The instrument was designed and tested prior to initiation of the second objective of the study. The **second** objective was to investigate the implementation of the accumulated guidelines, incorporated in the instrument, with sex offending programs in the state of Utah. The DYC recommended that initial efforts be focused on the evaluation of Level Six residential programs. These programs seem to be a midpoint between outpatient therapy and secured, lock-down facilities. NOJOS supported this focus primarily because their recommended guidelines, incorporated in the instrument, were designed for this specific population.

Six specific foci guided the research efforts:

1. Do the programs provide services for youthful sex offenders who present with appropriate target population criteria necessary for inclusion in a Level Six residential center? This specific question involves an examination of various factors used to determine admittance into a Level Six residential center. More specifically, it addresses criteria for the specified "Target Population."

2. Does the intake process meet contractual and "good practice" guidelines? Level Six residential centers are required by law to meet certain specified contractual guidelines. However, from an ethical standpoint, there are guidelines that have not been legislated yet but that will provide a focus for effective intake decisions.

3. Do programs offer and implement intensive JSO interventions? Interventions designed to specifically address antecedent, as well as maintaining factors, are critical to relapse prevention. An examination of the treatment constellation provides insight into the clinical efforts.

4. Do programs provide appropriate supervision of JSOs within the residential center and when they are outside of the center? It is critical that sexual perpetration be avoided to begin addressing the refocusing of the behavior, but also to protect other residents when the youth are

together. Additionally, as youth are permitted to go outside of the residential center, supervision must address the potential for offending in its varying contexts.

5. An examination of the quality of a program's aftercare is important in helping youth make a successful transition from the residential placement to their home, foster home, and so forth However, the transition has ramifications for relapse. The question of concern is, "Do programs provide an appropriate level of supervision to youth within and outside the residential center?"

6. Evaluation of staff training and credentials is of utmost importance. Thus, the question emerges, "Do staff have the requisite credentials and training to provide treatment to youthful sexual offenders?" Merely being trained as a clinician does not necessarily qualify one to work with this population. Guidelines to examine staff qualifications and training have been set forth by the National Task Force on Juvenile Sexual Offending (1993) and NOJOS (1996).

It is suggested that understanding implementation efforts of programs providing services to youthful sexual offenders, particularly when combined with recidivism rates, will direct attention towards refinement of efforts oriented in the treatment planning for youthful sexual offenders.

Limitations

Prior to expounding on the findings of this study, it is important to note several primary limitations that affect the interpretation of the data. The first limitation has to do with the groundbreaking nature of this study. As such, much learning has taken place and recommendations will be made to further refine the instrument and enhance effectiveness of its use in the study of implementation. Additionally, further work to establish the reliability and validity of the instrument in providing accurate information about residential center services is important. Second, the sample selected focused on youth who were in Level Six residential centers, but more specifically, on those youth who were in the custody of the State of Utah. This was essential for purposes of obtaining written consent from parents or guardians. However, this also eliminates

youth in these centers who were here from other states. Therefore, the number included in the sample was smaller than desired, ranging from 3 to 10. The third major limitation of the study was with the statistical procedures employed. Due to the sample size, and the unevenness of the sample from program to program, a number of assumptions associated with ANOVA, LSD, and derivation of standard scores were violated. Although much of the information could have been addressed by using only the percentages obtained, it was decided that employing these statistical methods, though biased, would permit the investigator to ascertain potential differences that may have clinical significance. It is understood that the violation of the assumptions increases the likelihood of both Type I and Type II errors. It was determined that by using these statistical procedures, given the limitations, data having clinical significance may emerge. This indeed was the case; in other words, statistical significance may have been an artifact, but the clinically significant information derived was most useful to the discussion, conclusions, and recommendations of this study.

With these three major issues in mind, the reader must be cautioned that conclusions and recommendations derived must be taken in the context of these limitations. No generalization is intended in the discussion, conclusions, and recommendations provided.

For purposes of this study, the conclusions will be divided into two specific areas. The first will address the strengths of the programs, which is interpreted to mean that for the items investigated all or most all of the programs were in compliance with guidelines, implementing the recommended interventions, and so forth The second focus will be on those areas that have clinical significance and where recommendations provided will be for the enhancement of program efforts in treating sexual offenders or furthering research efforts.

Strengths of the Programs: Conclusions

Strengths will be examined according to the six major foci of the study, addressing those foci and specific subcomponents of the foci.

Target Population

Understanding the nature of the target population is essential for effective and efficient treatment planning and reducing recidivism. The more Level Six residential centers admit a target population commensurate with their intervention capabilities, the greater the likelihood they will be successful in their treatment efforts, and thus the question, "Do the programs provide services for youthful sex offenders who present with appropriate target population criteria necessary for inclusion in a Level Six residential center?" It is suggested that understanding the target population is a critical issue at three major points in the treatment process: intake, treatment planning, and aftercare.

Risk characteristics of youth in Level Six programs. The risk characteristics of the youth in Level Six residential programs matched the criteria specified by NOJOS (1996) and the literature. The standards set by NOJOS (1996) described Level Six offenders as having displayed

> predatory or fixated patterns of offending: "use of force or weapons in committing their sex offenses," severe sexual acting out in terms of duration and intensity, and/or a "propensity to (sexually) act out with same-aged peers besides their victims. (p. 15)

Perry and Orchard (1992) defined force as threats, tricks, bribes, or physical coercion. Wenet and Clark (cited in Knopp, 1982) stipulated that any offender who used a weapon should be in residential treatment. Perry and Orchard's (1992) candidates for residential treatment include offenders who have multiple child victims and have escalated the frequency, duration, or type of aggression from a previous offense.

The logic of the eight-level system employed by NOJOS (1996) would suggest that there are at least two levels (seven and eight) where the risk characteristics would be more intense. Whereas Perry and Orchard (1992) divided risk characteristics into high and low, the use of a weighted risk might more accurately determine who should be assigned to secure residential treatment versus those who should be assigned to nonsecure residential treatment.

In answering the question, "Do the programs provide services for juveniles who present a level of risk appropriate for inclusion in a Level Six residential center?," eight items were incorporated in the study (Table 2.2). The results demonstrate that juveniles currently in Level Six programs are generally in conformance with current guidelines. Most of the youth had used force, increased the frequency, duration, or type of aggression from a previous offense, and had multiple child victims. The weighted risk of .57 suggests that on average, offenders in Level Six programs throughout Utah carry moderate risk in comparison with potential risk (1.0).

Need characteristics of youth in Level Six programs. The need characteristics of the youth in Level Six residential programs matches the need criteria of extant literature. The risk factors identified by Wenet and Clark, Perry and Orchard, and the JSOPPIT deal only with characteristics of the juvenile's offense. This focus is extremely narrow in that it parcels out the legal concern (the offender's transgression of the law by committing the offense) from a much wider field of characteristics that may increase the likelihood of a reoffense (e.g., social and emotional characteristics). This practice, although legally parsimonious, may not be in the best interest of society or the offender in terms of risk management. More recent work by Hawks (personal communication with Dr. Openshaw, 1997) incorporates the broad perspective needed for risk management purposes. Hawks has pointed out the importance of social and emotional characteristics associated with risk management relative to intake, monitoring progress on the treatment plan, and predicting and preventing relapse.

The concept of need adds an important dimension to the concept of risk in that it emphasizes the social/emotional rather than merely legal reasons for residential placement. The concept of need, however, is even less well-defined than the concept of risk. The boundaries between risk and need have not been clearly delineated. Perry and Orchard (1992) included reoffense after prior treatment among the risk factors. Need was defined by the Western Region DCFS (1996) as having a "prior history of sex offending treatment. . . extensive behavioral and emotional problems. . . cannot receive adequate supervision and treatment in group or foster sex

offender specific enriched homes" (p. 15). The literature fails to examine whether need and risk are synonymous, interactive, or additive. The relationship between need and risk is thus an important future research focus.

Most Level Six offenders, according to the results of this research, meet all the criteria specified by Perry and Orchard (1992) and the Western Region DCFS (1996). The findings suggest, as would be expected, that offenders in a Level Six program have less need (weighted need score = .67) of intense treatment than Levels Seven or Eight residents. Thus, it may be concluded that Level Six offenders present with moderate, rather than severe need.

Assessment protocols. The clinical protocols of the youth included either a Level B (psychosocial) or Level C (psychiatric) assessment as required by NOJOS (1996). Assessment serves a critical function in the overall decision with regards to acceptance of youth into a program (i.e., correct identification of target population), and acts as a foundation for further assessment aimed at guiding treatment planning, risk management, and relapse prevention. Three levels of assessment--A, B, or C--were applicable to the programs in this study. Most all of the programs (97%) had evidence of Level B or C assessments included in the client files.

Victimization experiences reported by youth. The programs were able to identify which youth had been victimized by abuse and neglect. Victimization experience refers specifically to whether youth in the program were victims of abuse (i.e., physical or sexual) or neglect. It has been posited that all males who commit sexual offenses have been sexually abused themselves, and those who do not admit to being victims might be denying victimization out of embarrassment (Hunter, 1990). It was noted in this study that 70% of the youth admitted to being sexually abused, and 68% admitted to being physically abused. Although this rate of abuse is considerably higher than the rate of abuse suggested by Ryan et al. (1996) for youthful sexual offenders, it is commendable that these programs would implement a methodology by which victims of abuse could be identified. A further issue is whether programs, once a youth has specified that they have been victimized, identify the perpetrators. Considerable variation was noted in the results section,

but it was evident that programs were attempting to ascertain this most important piece of information. Consistent with the literature, the majority of youth were victimized by their fathers/stepfathers. The history of abuse by the primary male role model in the lives of these boys points to the appropriateness of a clinical intervention with an out-of-home placement.

It is suggested that information regarding previous victimization experience and the relationship of the youth to the perpetrator has significant clinical implication. Programs are commended for their efforts in devising a method of collecting these data.

Sex offending profile of youthful perpetrator. The programs collected data on the sexual offending profile of the youth. Several questions facilitate the characterization of the sexual offending profile of the youth and expedite decision making with regards to whether they fit into the target population. The first question addresses the gender of the victim, thus attempting to ascertain whether the perpetration is homosexual, heterosexual, or bisexual. Data suggest that programs did utilize methods to ascertain the gender of the victim(s), with the results suggesting that the majority engaged in bisexual perpetration.

The second question of relevance addresses the age of the victim(s). As with the first question, programs employed a methodology to ascertain--as best as possible-- the age against which the youth in their program perpetrated. Most youth reported victimizing peer-age youth.

The final question examined the relationship of the perpetrator to the victim. Again, programs were diligent in examining this issue and reported that the majority of the youthful sexual offenders had victimized a combination of victims (i.e., family, acquaintances, and strangers). The preference of youth in perpetrating, when a single category was examined, was *family members*. The polymorphous, indiscriminate nature of the victim selection and the choice of family victims point to the need for residential treatment in a self-contained facility such as a Level Six program.

Sex offender residential placements prior to current placement. The programs were aware of the treatment/placement history of the youths in their particular program. It is not certain how the programs used this information. Intuitively, however, it would seem that a youth with a

long history of treatment or placement could have a higher risk of reoffending during the course of residential treatment as well as after release.

Intake Criteria and Procedures

Intake criteria and procedures outline the basic methodology by which youth are admitted into Level Six residential programs. Written materials such as policy and procedure manuals are the primary source of data. The strength of programs was noted in the intake procedures area, and more specifically as associated with "good practice" methods.

The quality of the program's first contact with clients and public agencies is governed by the program's intake procedures. Intake procedures that are organized, written, and distributed to potential clients and their parents or guardians do much to present a favorable first impression. The programs are to be complimented on their high rate of compliance with "good practice" intake procedures.

Treatment Constellation

The efficacy of the program's treatment constellation is the justification for the program's existence. If the program can provide evidence that there is a relationship between treatment plans, regulatory practices, modalities of therapy included in the overall therapy regimen, and a reduction in the overall recidivism rate, there is very good reason to support that program. This research examines all of the above except recidivism.

Specifically, this research was targeted at monitoring the extent to which the programs followed guidelines and "good practice" procedures, an essential step towards developing an efficacious treatment constellation. The intent of this research is to foster improved communication between agencies, state and local programs, and legislative constituents by providing documentation regarding treatment constellations as they presently exist and those desired.

Youth verbalization of content, depth, and breadth of treatment plan. The youth were able to verbalize an understanding of the content, depth, and breadth of their treatment plans. An understanding of treatment plan content was judged by matching words spoken by the youth with "The Qualitative Summary of Treatment Concepts" (Appendix A), a three-page, three- column document with words NOJOS experts suggested were descriptive of core therapeutic concepts in sex offender treatment. The average number of youth responses consistent with those of the experts was eight treatment words. It is difficult to ascertain how well this measure serves as an indicator of understanding considering that the pool consisted of approximately 300 words. However, the youth were able to at least identify terms relevant to their treatment.

As with content, the number of goals could be unlimited and not necessarily limited to sex offender specific treatment. During the interview the mean number of goals that were described by the youth was four. Caution must be taken in interpreting this as a strong indicator of the depth of understanding, but it certainly suggests that the youth were oriented towards some of the goals. A further caution is warranted because the study did not specifically identify the number of goals a youth had in the treatment plan, and so a comparison between the number listed and the number included could not be made.

The final indicator of understanding of their treatment plan was assessed by measuring the ability of the youth to identify specific categories around which treatment may be organized. Seven treatment categories were identified by the panel of experts with the youth identifying, on average, three. This is a positive indicator of their understanding of the breadth of the treatment plan. As with the previous two, interpretative caution is warranted. No data were collected that provided information regarding the number of categories included in the treatment plans.

Treatment goals. The treatment orientation of the programs in general focused on the teaching of attitudinal (cognitive) and social skills. Seven areas of treatment orientation were identified as critical to sex offender therapy (e.g., reducing cognitive distortions, healing personal victimization, decreasing deviant arousal, and so forth). Results of the study suggest that program

strengths were noted in the inclusion of treatment strategies specifically addressing cognitive distortions and increasing interpersonal competency. The category of cognitive distortions was addressed when treatment plans mentioned words such as "thinking errors," "honest, open disclosure," and "empathy." The category of interpersonal competency was addressed when treatment plans mentioned words such as "communication," "family problems," "socialization," "respect," and so forth. Ninety percent of the client charts included the category of remediating cognitive distortions, and 95% included the category of increasing interpersonal competency.

Medicaid treatment planning procedures. The programs complied withMedicaid treatment planning requirements. Only two charts in the sample lacking the necessary signature. Medicaid compliance is monitored frequently, as Medicaid provides the major source of funding for the programs.

Master therapy manual. The programs kept a master therapy manual. The item checking for a manual that outlines therapeutic procedures was taken from the Western Region DCFS (1996) instrument. The advantage of having a master therapy manual is that it systematizes therapy, explaining the policies and procedures associated with the specified program. Therapy will be planned and orchestrated according to the guidelines set forth in the manual. Such a manual provides an efficient method of ongoing program evaluation both within the program or if such is initiated outside. Although such a manual is not a "requirement" but rather a "guideline," it is encouraging to note that all programs had some form of a manual that guided their practice and decision making processes.

Weekly staffing. The programs were consistent in holding weekly staffing. DHS licensing (1991) requires that staffing be held weekly. Group staffing provides therapists with the opportunity to share knowledge and ideas regarding treatment of the youth. Weekly staffing provides an opportunity for team building between staff members. Most important, such meetings expand the vision and creativity of the therapist and provide backing for important decisions.

Treatment modalities. The programs implemented the requirements and guidelines set forth for a wide range of treatment modalities. Treatment modalities included family therapy, group therapy, individual therapy, adjunctive therapy, and skills development services.

Family therapy is advisable because the offenses perpetrated by the youth appeared, in many cases, to suggest that these youth grew up in families with evidence of poor family boundaries (Olsen, 1983). Lack of boundary differentiation in the family system was indicated by the high proportion of youth victimized by family members (Table 4.6). Thus a youthful offender may be an overt symptom of a dysfunctional family exhibiting serious pathology. In that extensive interaction with the family after release from the program is very likely to occur, it is commendable that many of the programs use this modality to address these systemic issues. It is suggested that such therapy could potentially interrupt much of the pathological dynamics that serve as family related antecedents to sexually offensive behavior.

With the exception of documenting the number of clients in the session for Programs 3 and 7, the programs generally complied with group therapy documentation. Group therapy is a principal intervention strategy commonly employed with youthful sexual offenders. It has proven to be an effective and efficient method of intervention, particularly when other supportive and adjunctive therapies have been included in the treatment regimen.

Medicaid requires that the date and time spent in individual therapy be recorded, and that the progress notes reflect a congruency with the treatment plan. The programs did very well in filling the Medicaid requirement. The DHS contract specifies that individual therapy should supplement group therapy, with which the programs fully complied. There was a minor difference, however among the programs on how often they offer individual therapy. The guideline on the DHS contract is one to two times weekly. Only one program offered individual therapy less than twice a week (Program 6). Program 6 was still in compliance, however, as the requirement is once a week.

The programs complied with the provision of adjunctive therapy. The programs either were associated with a network of nurses, doctors, and clinicians who provided the adjunctive therapies, or incorporated the professionals into their own staffs. The provision of adjunctive therapy was recorded in the client file and sometimes in a separate medical log.

The skills development services of the programs appeared to be fulfilling the expectations of NOJOS (1996) and the DHS contract in the provision of life skills training. It is important that programs take the position of preparing youth to reenter society. Some of these youth will reenter as adults and be required to move into independent living situations. This necessitates that they be prepared to make this transition effectively. Life skills training provides a "mainstreaming" effort that is commendable.

Supervision

The literature is clear on the subordination of the offender's need for treatment to the needs of the community and victim for safety (Barbaree & Cortoni, 1993; National Task Force on Juvenile Sexual Offending, 1993). The goal of supervision is to protect potential victims from sexual offense. Potential victims exist not only in the home and community, but also within the program. Protection must be extended during home visits, community-based recreation, and school. Protection to other offenders within the program is a particular challenge. As noted in the findings of this study, offenders in the program are accustomed to the role of both offender and victim. Programs must take every precaution to protect the offenders from victimization. Programs should be particularly vigilant when offenders are in vulnerable times and places (e.g., bedroom and bathroom; during unstructured time such as when engaging in sports, and so forth). The following areas of strength in supervision were noted:

Staff supervision of youth. The programs complied with staffing requirements. The programs complied fully with 24-hr/day awake supervision. Generally, the staff were in close proximity to sleeping quarters, such that staff could observe the youth when leaving the room; however, there were situations in which the youth were upstairs while staff were downstairs. Most

programs provided at least a 1:3 staff client ratio during day, with only one having a ratio of 1:2. Supervision is most difficult and programs involved in this study should be complimented for their diligent efforts to provide appropriate staff supervision.

Facilities' composition.The facilities were designed and furnished to meet supervision requirements. Most of the programs had facilities they had purchased or rented, which initially restricted their freedom to design and provide a secure and safe living environment. However, these programs generally compensated for this problem and met the contractual requirements.

Some of the general requirements noted in the contract included: (a) having 60 square feet per occupant in multiperson rooms, not including storage space, (b) providing one bathroom per six residents, (c) providing natural light and ventilation in bedrooms and bathrooms, (d) no more than four occupants per room, and so forth. Compliance with these requirements was noted in all aspects, except Program 1, which did not have the required number of bathrooms. Fortunately, this discrepancy involves more of an inconvenience than a security issue.

Policy and procedures manual. The programs kept a policy and procedures manual. A policy and procedures manual facilitates control by providing a systematic protocol for dealing with day-to-day issues. Through the instructions given in the policy and procedures manual, staff know how to prevent victimization and how to respond in the event that it occurs. All of the programs had a policy and procedures manual.

Behavioral management system. The programs had instituted a behavioral management system. The behavior management system is a protocol of rules that govern both staff and youth behaviors. It defines how staff are to respond to youths' misconduct in a manner that protects as well as disciplines the youth. The programs complied fully with having a behavioral management system.

Peer transmission of rules. The data suggest that the peer culture may be the most powerful transmitter of rules. Of interest to this study was the fact that for all categories of rules (bedroom, bathroom, and interpersonal), the youth matched each other more often than line

workers or when compared with the written rules. It is recommended that programs capitalize on this finding, perhaps through the development of a peer advisory committee that would be made up of those nearing "graduation."

The evaluator noted another strength with regards to rules and the youth in the program. In listening to the youth discuss rules, it was noted that most of them could not only recite a rule, but could also list a plethora of reasons that rule was essential to the well-being of the youth in the program. Such programs are to be commended for teaching the rules as facilitative of well-being rather than as restrictions to having fun.

Home-visit guidelines. Results of this study suggest that programs are making a concerted effort to monitor home-visits in such a manner so as to prevent reoffending.Home visit guidelines were adopted from the Western Region DCFS (1996). It is important that programs define expectations for youth and parents during home visits as a preventative measure. A reoffense is tragic to the victim as well as to the offender's progress in the program.

Aftercare

Between the time a youth enters and leaves the program, it is hoped that intervention will have produced healthy change and growth, thus enabling relapse prevention. Sending a youth back without emotional and clinical support to face the family and social circumstances that served as antecedents to the abuse is not acceptable. It is essential that supportive aftercare be provided to help the youth maintain his change. Strength in aftercare planning and execution was manifest by the following:

Availability of continuum of care. Continuum of care refers to a hierarchy of services and supervision available to the youthful offender such that an offender at a higher level will work his or her way down to the lowest level before supervision and treatment are terminated. Youth in a Level Six placement are high in the hierarchy of continuum of care (Gerdes et al., 1995). Upon release from Level Six, they step down to a medium level of service and supervision. Aftercare programs are generally at a Level Two care stage--typified by outpatient services and monitoring.

Sometimes, however, a Level Three (day treatment) or Level Four (structured home such as would suit a nonsexual offender) is necessary. Although it is desirable that a program have all these levels available through either their own or an allied agency, having Level Two care available is most essential. All of the programs had at least Level Two services available. Six out of seven of the programs also had Levels Three and Four accessibility.

Documentation of aftercare services. The aftercare services of the programs were documented as required by the DHS contract. The requirements of the DHS contract seem to be intended to ascertain whether programs will perform a discharge with a safety plan in mind, rather than leaving the plan to "whim." Two examples include, "Is a copy of the aftercare plan attached with the youth's discharge summary from the facility?" and "Has the aftercare plan been jointly defined and agreed on by program treatment and DCFS staff?" The .89 implementation rate suggests that, generally, documentation is appropriate.

Summary of Program Strengths

1. The youth in Level Six programs had, for the most part, a degree of risk and need appropriate to admittance into a Level Six residential program.

2. Ninety-seven percent of the client files in Level Six programs contained Level B psychosocial and/or Level C psychosexual assessments.

3. The programs had collected data on the type of victimization (sexual, physical, neglect) their youth had experienced and who their perpetrators were.

4. The programs had collected data on the gender, age, and relationship of the youthful offender to his victim.

5. The programs collected data on the previous treatment and placement experiences of the youth in their program.

6. The programs utilized "good practice" intake procedures.

7. The youth in the programs appeared to understand the content, depth, and breadth of their treatment plans.

8. The programs included treatment strategies specifically addressing cognitive distortions and increasing interpersonal competency in their treatment plans.

9. The programs complied with Medicaid treatment planning procedures.

10. The programs all had master therapy manuals.

11. The programs were consistent in holding weekly staffing.

12. The programs generally did well in implementing the requirements and guidelines set forth for these treatment modalities of family therapy, group therapy, individual therapy, adjunctive therapies, and skills development services.

13. Programs provided adequate staff supervision of youth.

14. The programs generally met the requirements of the contract regarding the facility's composition (e.g., square footage of bedrooms, number of bathrooms, and so forth).

15. All of the programs had a policy and procedures manual.

16. The peer culture appeared to be a powerful socializing force in the transmission of knowledge about rules.

17. The youth not only recited the rules, but also listed a plethora of reasons why obeying the rule would facilitate their well-being.

18. Programs made an effort to monitor home visits in order to prevent reoffending.

19. The programs generally had the full availability of continuum of care.

20. The programs maintained documentation of their aftercare services.

Enhancing Clinical and Empirical Effectiveness: Conclusions and Recommendations

Items addressing varying aspects of implementation allowed the investigator to understand which programs were effectively employing state guidelines and recommendations by key agencies in their programs. Due to the social concerns about this population of offenders, it is believed that the more programs concertedly implement recommendations as they evolve,

regardless of whether they are state guidelines or recommendations from key agencies, the more effective their programs will be in addressing sexually offensive behavior and decreasing recidivism.

Target Population

Risk management: Focusing on behavioral and emotional, as well as legal concerns from intake through release. The programs are to be commended for meeting the criteria for risk and needs independently. However, risk management goes beyond that of merely intake. In fact, it is posited that risk managment has implications from intake through release. Thus, whether an offender used a weapon or other means of force, victimized a peer, or physically inflicted harm has relevance as the offender progresses through the program. As important as it is to understand the method of aggression, the concept of need takes a place of relevance in the conceptualization and implementation of risk managment (Hawks, 1995/96). Physical, social, and emotional needs of the offender provide a context in which to understand the behavioral manifestation of risk and as such, are essential concerns. An example of the need for a more extensive (breadth and depth) assessment of risk (e.g., the inclusion of need factors) is found in the literature. Graves (1993) demonstrated that offenders present with sexually deviant behaviors and emotional problems that appear to be contextualized (e.g., experience with significant others). Thus, strict focus on the act of offending ignores the basic humanistic nature of the offender that must be therapeutically addressed to decrease the probability of reoffending. Consequently, discharging a sexual offender without these considerations incorporated into the treatment regimen, because of their relationship to relapse, may be viewed as unethical.

It is recommended that programs work towards a risk management protocol, that has sufficient breadth and depth to allow for assessment of risk not only at the time of intake, but also throughout the program and during aftercare; and that can be used to prognosticate relapse potential. Such a risk management protocol will necessitate the combined efforts of agencies in

the formulation of an appropriate protocol. This protocol will then need to be subjected to empirical investigation to ascertain its reliability and validity in predicting relapse.

Enhancing diagnostic effectiveness. The identification of psychopathology in JSOs is important not only for Medicaid compliance, but also for risk assessment and management, as well as treatment formulation. Unfortunately, the variation in diagnoses between the programs suggests that the programs had very different target populations, the therapists were not trained in DSM IV diagnostic criteria, or the purpose for diagnosing was lightly ascribed to collecting Medicaid funds.

The major mental health characteristic differentiating Level Six offenders from Level Seven offenders is that Level Seven offenders present with psychotic processes, self-destructive behavior, and/or severe aggression (NOJOS, 1996) that requires medical stabilization. One would expect to find offenders in Level Six programs whose mental health problems, although seriously interfering with functioning, are manageable without the unmedicated offender presenting serious threat to himself or herself or others. The results indicate that disorders usually not treated by medication occurred with greater frequency than disorders that could be treated with psychoactive medication. Currently, Utah has no Level Seven programs, which may account for the 16% of youth in Level Six programs who manifest psychotic behavior. Utah is, however, expected to have a Level Seven program within the next 6 months (Fowers, personal communication, April, 1997).

The DSM IV (American Psychiatric Association, 1994) organizes the categories of symptoms along several axes. Axis I, the symptom disorders, includes disorders such as depression, anxiety, and schizophrenia. Axis II disorders include personality disorders, mental retardation, and developmental disorders. With the exception of features of personality disorders, all of the categories listed in the JSOPPIT were Axis I disorders. The disorders found to be statistically significant and clinically relevant included sexual disorders, conduct disorders, impulse disorders, mood disorders, and features of personality disorders.

Sexual disorders are referred to as "paraphilias" (American Psychiatric Association, 1994). Sexual disorders begin to manifest themselves in adolescence. Some sexual disorders, such as exhibitionism or voyeurism, do not involve direct contact with the victim, and therefore have lesser legal penalties. Pedophilia involves recurrent and intense, sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with children. If acted out by an adolescent or an adult, pedophilia has serious legal consequences. To be diagnosed as having pedophilia, the person must be at least 16 years and at least 5 years older than the child or children who are the objects of his or her urges or behaviors. Whatever the psychiatric classification, it is still unlawful for a child or adolescent to sexually and nonconsensually engage another child, adolescent, or even an adult. It is important, according to the DSM IV (American Psychiatric Association, 1994), to specify three characteristics when making the diagnosis of pedophilia: (a) the sex or sexes to which the pedophiliac is attracted, (b) if the behavior or attraction is limited to incest, and (c) whether the attraction is *exclusive* (attracted only to children) or *nonexclusive* (attracted also to adults). Generally, therapists in the programs did not identify specific characterizations when rendering a diagnosis of sexual disorder. The term "sexual disorder" appeared to be used as more suggestive of psychopathology, rather than specifying specific paraphilia (e.g., "fetishism," "frotteurism," "sexual masochism," "exhibitionism," and so forth).

Conduct disorders involve a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated. The behavior of conduct-disordered youth involves aggression toward people and animals, destruction of property, deceitfulness or theft, or status type offenses. As with any Axis I disorder, it is imperative that the clinicians providing the diagnosis specify not only the specific behaviors that lead them to the diagnosis, but also clarify whether the disorder is of childhood or adolescent onset, and provide an indication as to the severity. Of critical importance is the fact that "sexual perpetration" is identified as a characteristic associated with the diagnosis of conduct disorder. Unfortunately, the differentiation between "sexual disorder" and sexual acts associated with "conduct disorder" was

not presented in the cases. This is of considerable concern when one considers diagnosis precedes treatment planning. Without such a posture, it is possible that adolescent recidivism (Openshaw & Barlow,1997) is high because diagnoses were not accurately obtained and treatment may have been focused on the wrong set of diagnostic criteria.

Of considerable interest is the fact that recent literature (Graves, 1993; Miner & Crimmins, 1997) suggests that youth presenting as sexual offenders are, in reality, conduct disordered youth. If this is the case, it is recommended that perhaps the personality features commonly seen in youthful sexual offenders are more consistent with the antisocial personality and to a lesser degree correlated with either the narcissistic and borderline personality. The appropriateness of a diagnostic label, personality disorder, awaits the minimum age of 18, but features of personality disorders can be identified at an earlier age. It is essential that clinicians not only identify these features but also associate them with the appropriate personality orientation. For purposes of future research, some clinicians (e.g., D. K. Openshaw, personal communication, April, 1997) suggest that conduct disorder appears to be a premorbid orientation to the antisocial personality, whereas those youth who are sex offenders, not conduct disordered, will present more commonly with characteristics associated with either the narcissistic or borderline personality. These delineations are encouraged so that conceptualization can be furthered and treatment strategies more individualized.

A less similar but intense disorder of conduct is "oppositional defiant disorder." As with the clarification associated with conduct disorder, relative to sexual disorder, this particular diagnosis appeared to have been subsumed into the overall diagnosis of conduct disorder. It is recommended that more precision be given to diagnosing and that such assumptions not be incorporated.

Impulse disorders is a catch-all term for problems of impulse control that are not classified within another diagnostic area. Impulse disorders include "intermittent explosive disorder," "kleptomania," "pyromania," "pathological gambling," and "trichotillomania." Intermittent

explosive disorder involves several discrete episodes of serious assaultive acts or destructions of property that are grossly out of proportion to any precipitating psycho social stressor. Kleptomania is a failure to resist impulses to steal objects not needed for personal use or for their monetary value. Pyromania is deliberate and recurrent fire setting. Pathological gambling involves a preoccupation with gambling that is not remediated by the negative consequences associated with gambling. Trichotillomania is defined as the recurrent pulling out of one's hair, resulting in noticeable hair loss. In the context of this evaluation, impulse disorder was limited to a premorbid orientation towards a sexual disorder, in particular pedophilia. Perhaps it may have been more appropriate, when one considers the specifics of this particular disorder, to have either diagnosed the youth who demonstrates a pedophilic orientation, but can not meet the criteria (e.g., not of age) with either sexual disorder NOS (not otherwise specified, hereinafter referred to as NOS) or impulse disorder NOS. Clarification of diagnosis is essential to treatment planning, risk management, and decisions regarding discharge.

Mood disorders include varying degrees of major depression, dysthymia, and bipolar depression. Major depression includes symptoms such as a depressed mood, markedly diminished interest or pleasure in activities, weight loss or gain, insomnia or hyposomnia, psychomotor agitation or retardation, fatigue, feelings of worthlessness or guilt, difficulty concentrating or making decisions, and suicidal thoughts. Whereas major depression is acute, dysthymia is a chronic form of depression with symptoms including a chronically depressed mood, with presentation of two of six symptoms (i.e., disturbances of appetite, sleep, energy, self-concept, concentration, or feelings of hopelessness). Bipolar depression involves a period of depression as well as another distinct period when the mood is distinctively elevated, expansive, or irritable. During the period of mood disturbance, other symptoms are present such as inflated self-esteem, decreased need for sleep, logorrhea (talkativeness), flight of ideas, distractibility, increased goal-directed activity, and excessive involvement in pleasurable activities that have a high potential for painful consequences.

Many youth were diagnosed with "mood disorder" or "mood disturbance" as with other diagnoses, but there were insufficient data to permit clarification of not only the specific mood disorder, but also the qualifying criteria thereof.

A personality disorder involves an enduring, inflexible, and pervasive pattern of inner experience and behavior that deviates markedly from the expectations of one's culture. This pattern is manifested in at least two of the four following areas: cognition, affectivity, interpersonal functioning, and impulse control. The pattern of inner experience and behavior must lead to clinically significant distress or impairment in social or occupational functioning. Additionally, the pattern must be stable and can be traced back to adolescence or early adulthood. There are a number of personality disorders with different names. The most common personality disorders listed on the youths' diagnoses were borderline and narcissistic personality disorders. Borderline personality, in brief, involves a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity. Narcissistic personality disorder involves a pervasive pattern of grandiosity, need for admiration, and lack of empathy.

In interviewing therapists, it appeared that much of the variation had to do with what a given therapist believed about JSOs. For example, the therapist in Program 1, who diagnosed all offenders as having Impulse disorders, stated to the evaluator that this was done because the DSM IV did not permit the assignment of sexual disorder until a juvenile was the age of the majority (this is true only for the diagnoses of pedophilia, where the individual must be at least 16). The Program 7 therapist, on the other hand, gave almost no diagnoses except personality and sexual disorders. Another therapist stated a reticence to label juveniles as having a personality disorder until they were 18, and instead listed ostensible personality disordered features as a deferred diagnosis. This assumption is accurate, but according to the DSM IV, as previously indicated, delineation of the features needs further study.

It is recommended that therapists working on common goals speak a common language. If diagnoses are used to obtain Medicaid reimbursement and provide definitions for problems that

JSOs have, therapists should work together to improve the reliability of diagnoses. Precision in diagnoses is especially important if diagnoses are used to guide treatment planning. At least part of the issue is that DSM IV diagnoses have problems with reliability by their nature. For example, the DSM IV (American Psychiatric Association, 1994) organizes diagnoses categorically. Categorical diagnoses involve using the presence of specific symptoms to render a diagnosis. Categorical diagnoses allow for recognition, quick communication, and quick judgment. Ambiguous terms such as "causes significant distress" or "impairment in functioning" or "most of the time" are used to stipulate how much or how often a given symptom needs to occur to be relevant. Much room must necessarily be left for clinical judgment.

A second recommendation is to increase the training requirements for those rendering the diagnoses. The clinicians making the assessments were qualified to make the diagnoses according to Medicaid (DCFS/DYC, 1995) and NOJOS (1996) standards, meaning that they were licensed and they generally had over 2,000 hr of juvenile sex offender specific experience with 50 hr of supervision. NOJOS (1996) is currently working on a certification obtained after specialized training and supervision in treating JSOs. Perhaps this measure will bring greater standardization.

Another important recommendation would be to combine both dimensional and categorical classifications, which would allow the clinician a better method of not only gaging risk, but also of determining risk management and treatment strategy and predicting relapse. Dimensional diagnoses rate symptoms along a continuum. The weighted indices used in assessing risk and need provide an example of a dimensional classification. With further conceptualization (R. Hawks, personal communication with Dr. Openshaw, December 1996), this aspect of diagnosing would become an most essential element in the overall treatment process. Thus, rather than merely assigning the category "sexual disorder, conduct disorder, and so forth," a necessary condition, it is suggested that the dimensional diagnosis provides the sufficient condition in the overall planning for youthful sexual offenders.

Regardless of how programs decide to coordinate efforts in providing consistent diagnoses for youthful sexual offenders, it is critical that further research assess the reliability of these diagnoses, the purpose for making diagnoses, and whether there is some degree of consistency in the diagnoses according to program. It is likely that some programs, for example Program 5 in this study, may be more adept in accepting youthful sexual offenders who are also conduct-disordered than other programs. This understanding, therefore, could be used in determining the best placement for a youth.

Of considerable interest is the fact that recent literature (Graves, 1993; Miner & Crimmins, 1997) suggests that youth presenting as sexual offenders are, in reality, conduct-disordered youth. If this is the case, it is recommended that perhaps the personality features commonly seen in youthful sexual offenders are more consistent with the antisocial personality and to a lesser degree correlated with either the narcissistic and borderline personality. The appropriateness of a diagnostic label, personality disorder, awaits the minimum age of 18, but features of these can be identified at an earlier age. It is essential that clinicians not only identify these features but also associate them with the appropriate personality orientation. For purposes of future research, some clinicians (e.g., K. D. Openshaw, personal communication, April, 1997) suggest that conduct disorder appears to be a premorbid orientation to the antisocial personality, whereas those youth who are sex offenders, not conduct-disordered, will present more commonly with characteristics associated with either the narcissistic or borderline personality. These delineations should be made so that conceptualization can be furthered and treatment strategies more individualized.

Assessment protocols. Because assessment has such an important role in all aspects of the Level Six programs, it would seem prudent to obtain as much information as possible regarding the youth being admitted into their program. As previously noted, three initial assessments are possible to locate in the charts; however, only one program had a Level A assessment, and there was a mixture of those having a Level B and C in the files.

Information in Level A assessments outlines the offense circumstances (e.g., pleadings or protest of victim), the history (prior intervention, prior delinquency), the quality of the custodian's supervision of the juvenile (custodian denies offense; custodian cannot or will not facilitate clinical intervention), and the juvenile's attitude towards supervision and clinical intervention at the point of the initial contact with the state. The assessment of the juvenile at the time of intake contains some similar information, but rates that information at the time of intake. Further, that information is generally limited to describing the history of sexual and nonsexual offenses.

The difference in parental or juvenile attitude toward the offense at time of first contact with the legal system should be a matter of concern in treatment planning. An offender and parents who initially deny or minimize the offense may have, for example, a need for a different intensity or adaptation of treatment services. Sefarbi (1990) found substantial differences in family organization, parental nurturance, and self-esteem between JSOs who admitted their offenses prior to treatment and those who denied them. Treatment planners can be aware of the relationship between deniers and family organization, nurturance, or self-esteem. Treatment goals and practices can be focused with the knowledge that denial and minimization are symptoms of larger problems that need to be addressed along with the sexual pathology.

It is strongly recommended that the programs insist that a copy of the Level A assessment be sent at the time of intake. The assessment would provide information that could be essential to treatment planning. It is further recommended that client files also contain both Level B and Level C assessments. Each of these assessments consists of different, yet not mutually exclusive, data pertinent to the overall decision regarding acceptance of the youth into the residential program. Additionally, these three assessments can provide initial data pertinent to treatment planning, development of ongoing assessment procedures for individual youth, and an understanding, prognostically, of relapse potential.

Previous sex offender residential placements prior to current placement. Due to the uncertainty as to how placement information is used, comments are included to portray potential

methods of strengthening programs in the selection of youth through their understanding of these data. Caution is warranted in that the study did not ascertain whether programs used these data in their decisions regarding admittance into their programs.

Two questions guided this particular focus of the study. The first addressed the number of previous residential sex offending placements youth had had prior to being assigned to a Level Six residential program as reported by their therapist to the evaluator. All of the programs employed a method of including these data in their decision-making process. The second question, though similar to the first, was slightly more complex and was ascertained by asking youth in the current residential placement the number of (a) previous sex offender residential placements, (b) sex offender specific outpatient episodes, and (c) months they had been in the current placement. Considerable variation, though not at a statistically significant level, was noted. It appears that knowledge regarding previous placements and treatment methodologies would help guide the decisions about the appropriateness of the youth in their program. For example, it was noted in the data that Program 5 had more conduct-disordered youth and, in general, had youth who appeared to present with more severe symptomology in general. Coordinated efforts, understanding of program limitations, and treatment regimens may need to be taken into consideration when selecting the most appropriate placement for youth. It is recommended that a central intake for youthful sexual offenders be organized, independent of the programs, for ascertaining the therapeutic needs of the youth and correlating these needs with the target population criteria of the individual programs. Youth would be assigned to the program based on the ability of the program to meet the specific, as well as general, needs of the youthful sex offender.

Intake Criteria and Procedures

Programs included in this study generally did not have written intake criteria. The program representative who provided this information to the interviewer almost always commented that intake criteria were a "clinical" decision made by the therapists after screening a potential candidate. It is unclear what the advantages would be to relying solely on clinical decision making

to determine eligibility. Perhaps the lack of written criteria would give a program more flexibility to accept a needy but difficult candidate. The flexibility might enable the program to be more responsive to the community's needs. For example, during the time of this research, the Utah State Mental Hospital terminated its residential services to mentally ill sex offenders. The program has had to bear the burden of accepting these mentally ill offenders. Written intake criteria may have precluded the program's ability to adapt to the community's need.

Many advantages to the use of written intake criteria are apparent. Written intake criteria have the potential to channel the programs into specialization. For example, programs could focus their services on the learning-disabled offender, mentally ill offender, conduct-disordered offender, and so forth. This specialization would encourage the development of specialized skills for treatment providers and provide youth with interventions that focus on their special needs.

Another advantage is in the clarification of the program's expectations to the community. Some of the program representatives stated that their program was very selective of its candidates for admission, and that almost as many youth were turned down as were accepted. Candidates for admission may not be rejected nearly so frequently if eligibility criteria were readily available to referents.

It is strongly recommended that programs examine this issue of intake criteria and exert a concerted effort to clarify what the intake criteria are, and make them consistent with recommendations from specific organizations evaluating sexually offensive behavior (e.g., NOJOS), as well as those specified by contracts (e.g., DHS).

Treatment Constellation

Treatment constellation refers to the overall treatment regimen designed for the youth and implemented through the various methods employed by the programs. Several areas were noted in this study that seem to have relevance for enhancing the treatment planning and strategies for youthful sexual offenders. Some of the recommendations may be employed by

programs, but there was insufficient evidence in client charts or program manuals to support that these were consistently being used.

Target population. From the data obtained, it appears that there is variation in the types of youth accepted in various programs. For example, Program 5 reported that 52% of its youth had had three or more placements and had the most fathers abusing the boys (100%), the most mothers/stepmothers abusing the boys (68%), and the most frequent diagnosis of conduct disorder (100%). This again suggests a need for strengthening assessment procedures, understanding the capabilities of the programs, and making a determination prior to placement.

Treatment goals. Treatment goals were oriented around seven specific categories. To enhance the effectiveness of programs it is recommended that those categories that were least likely to be specified in the treatment plans be attended to more directly. The most often neglected was that of healing personal victimization. As noted, Level Six residential programs were quite effective in identifying which youth had been victimized previous to their offense, or may have been victimized during their period of offending behavior. What is of concern is the second element, which goes a step beyond the issue of mere identification to the question of, "How do programs incorporate information about victimization into the overall treatment plan of youth in their program?" Whereas 70% of the youth presented as victims of abuse or neglect, only 2% of the client files ($n = 1$) suggested a treatment plan that incorporated therapy for victimization. Such an element of treatment is of utmost importance and may even precede effective intervention for offending behavior. Muster (1992) noted that treatment usually focuses on the offense rather than the offender's own victimization. Muster found that experts in the corrections field favored the more punitive, confrontational approach of dealing first with the offense, whereas therapists preferred dealing with the victim issues first. Therapists did not feel that focusing on victim issues first compromised the offender's ability to own up to his or her offense. It is recommended that all previously victimized clients be treated for their victimization, and that research efforts be initiated

to examine where the most effective point of therapy is. Further research into this suggestion is warranted.

Another area that was not specifically addressed in the seven areas, but may have been inclusive in several of them, has to do with the offense history of the perpetrator. It is evident that programs focus on the offense history in that their treatment strategies are sex offender specific; however, it was noted that there is considerable variation between programs in both the age of victims and the relationship of the offender to the perpetrator. It was not clear from data provided that these areas were consistently included in treatment planning. This may be due to where the data were taken from and, thus, caution is warranted.

Comparison between youth and line worker's understanding of the treatment plan. It was of interest to observe the differences in the data that were oriented around the understanding youth had about their treatment plan and that of the line workers. It was assumed that either the line workers would have a more expansive understanding or that they would at least be on par with the youth. This was not the finding in any of the three areas, content, goals, or categories. The reasons for the discrepancy may be attributed to the methodology of the study in that certain factors may have confounded the data (e.g., length of time working with the youth, part-time vs. full-time employees, and so forth). Regardless, from a clinical perspective it is be important that line workers be quickly and adequately assimilated into the program and that their understanding be sufficient to facilitate therapeutic endeavors. Future research needs to consider potential confounding factors and take these into consideration.

Recreational compliance. Although the programs complied fully with having "at least two recreational activities per week," and "planning [some] of them in advance," a difference between the programs was observed. Some of the programs had made a formal plan and had written recreational activities several weeks in advance. Other programs just planned on a day-to-day basis. Planning on a day-to-day basis does not seem to serve therapeutic planning well. By this it

is meant that incorporating recreational activities into the treatment plan merely to be there seems to miss the concept of orchestrating the various types of interventions toward the same purpose. It is recommended that recreational plans be assimilated into the treatment plan in such a manner so as to appropriately support intervention efforts.

Quarterly summary. The quarterly summary is a document that facilitates communication between the program and DCFS or DYC. It is required, by contract, not only that the quarterly summary be sent, but that it be documented in the chart that it was sent. Although there was a relatively low rate of compliance with the quarterly summary requirement, the problem appeared to be in documentation rather than action. Some of the programs neatly documented sending quarterly summaries on the bottom of their treatment plans; others used sticky notes. It is recommended that programs be more scrupulous in fulfilling the requirements of the contract regarding the documentation of sending quarterly summaries.

Supervision

Supervision is critical to the ongoing aspects of daily living in a Level Six residential program. This is carried out in many ways and can always be strengthened. The following are suggested areas for future examination and enhancement.

Monitoring system. The typical electronic monitoring device was a motion sensor placed in proximity to the youth's bed. If the youth crossed the room to go over to his roommate's side, the motion detector would be activated. One program provided visual scanning by a camera of the rooms every few seconds. A worker sits at the desk watching all the rooms on a monitor screen. Unfortunately, almost half of the programs did not have electronic monitoring systems of any type. It is understood that staff are present 24 hr a day, but they cannot be in all places at all times. Thus, it is recommended that programs involved in the residential treatment of youthful sex offenders use an electronic monitoring system.

Program rules supporting supervision efforts. The implementation rate of .80 was due to the programs not having written rules specifically about youth behavior in bedrooms and

bathrooms, or guiding their interpersonal interaction. For example, it was more common to find a general written rule such as, "No horseplay," than specific rules such as "Bathroom visits are limited to no more than 3 min," and "Youth may enter other residents bedrooms only when approved and supervised by staff."

It is posited that when general rules are provided that youth tend to manipulate the rule in favor of their behavior, thus making it difficult to effectively and appropriately enforce a consequence. It is recommended that rules should be specific and positively written. Further, these rules need to address the most vulnerable aspects of the residents' offending behavior and the contexts in which these behaviors may occur. In addition, it is suggested that for each rule that there be a clear and concise consequence designated that is either natural or logical. The concern is not that the program did not espouse rules about bedrooms and bathrooms-- the youth could recite rules regarding these places-- but, rather, rules were often not written down for reference purposes.

The decision-making strategy used when making room assignments is also a problem. This strategy is not written down. Failure to put the decision-making strategy into writing calls into question whether there is a strategy that is followed with any consistency, and raises the question about assignments being made as a matter of convenience. It is important for programs to be accountable and have the documentation to prove their seriousness about protecting youth.

Aftercare

Aftercare is a most vital component to the therapy process. It provides the mechanism for mainstreaming youth from the residential center back into full active participation in their family and society.

Modalities and duration of aftercare. NOJOS (1996) and the DHS contract specify that during the aftercare period that programs continue to use individual therapy as an adjunctive intervention to group therapy. Even though experienced therapists have espoused group treatment for adolescents because of their high susceptibility to peer influence (Lightfoot & Barbaree, 1993),

it was found that Programs 1, 2, and 4 used individual therapy as the primary modality for intervention during the aftercare period. It is recommended, at least as long as present research continues to substantiate the role of group therapy for this population, that group therapy be continued to be used as the primary therapeutic modality even during the aftercare time period.

NOJOS (1996) guidelines indicate that aftercare should extend 6-12 months after release from a Level Six program. The impact of length of aftercare on recidivism is unknown, but it is reasonable to assume that longer aftercare better facilitates a firmer transition to a nonoffending lifestyle. With this in mind, it was found that only one program, Program 3, did not have aftercare services that extended at least 6 months. It is recommended that Program 3 examine its rationale for the length of aftercare and use some research methodology to determine the appropriateness of the length of time they provide it. It is possible they may find that the youth in their residential center may be an exception and a shorter period of time would serve them just as well. However, until such is substantiated, it would seem prudent to focus on providing a longer aftercare time period for these youth.

Tracking recidivism. Tracking recidivism, regardless of whether the crime is sexual, nonsexual, or a combination, was the weakest aftercare area examined. Only 42% of the programs attempted to track recidivism, with most of that percentage using an informal technique that is methodologically problematic. The failure to track recidivism is the failure to control for program quality. Ethically (e.g., are the programs providing the appropriate interventions for the population?), as well as potentially legally (e.g., is there sufficient understanding, prognostically, to determine the level of risk management as the youth leave the residential center?), there are serious concerns when the administrators of programs with such high-risk youth fail to determine the overall effectiveness and efficiency of their program. Recidivism is one of the critical elements used in determining outcome effectiveness of programs.

Staff Qualifications and Training

The credentials of staff are important not only in assuring quality care but also in helping to maintain the program's financial viability. Therapists and residential staff in the area of juvenile sex offending appear to require specialized skills not required of therapists and residential staff in other mental health endeavors. This specialization is believed to be essential to prevent the therapist from becoming, for example, entrapped in the offender and his or her family's system of denial (NOJOS, 1996).

Annual background checks. The DHS contract specifies that personnel files contain BCI and USSDS checks. Yearly BCI and USSDS checks were recommended by the Western Region DCFS (1996). Though all of the programs had the required BCI and USSDS documents, Programs 3, 6, and 7 did not have a yearly update. Yearly rechecks are important to verify that therapists and line staff have no new criminal or child abuse charges. We strongly recommend that BCI and USSDS background checks be updated annually.

Documentation of therapists' experience. Programs 3 and 4 did not have documentation of the therapists' experience working with juvenile offenders. The administrators interviewed stated that the therapists maintain their own records documenting their clinical experience. This becomes an issue of accountability, which is both an ethical as well as a legal concern, for the specific programs. When clinicians do not have to provide documentation, it is difficult for programs to determine if the clinicians have met training and supervision requirements. We strongly recommend that programs be held accountable to document the experience and training of their staff.

Summary of Recommendations

1. The programs should work towards a risk management protocol that has sufficient breadth and depth to allow for assessment of risk not only at the time of intake, but also throughout the program, and during aftercare. The protocal should also be used to prognosticate relapse potential.

2. Clinical diagnoses of youthful sex offenders should receive greater standardization.

3. The training requirements for clinicians making diagnoses should be increased.

4. Both dimensional and categorical diagnostic classifications should be used to allow the clinician a better method of not only gauging risk, but also of determining risk management and treatment strategy and predicting relapse.

5. Programs should insist that a copy of the Level A assessment be sent at the time of intake.

6. A central intake for youthful sexual offenders should be organized, independent of the programs, for ascertaining the therapeutic needs of the youth and correlating these needs with the target population criteria of the individual programs.

7. Programs should examine the issue of intake criteria and exert a concerted effort to clarify what the intake criteria are and have them consistent with recommendations from specific organizations evaluating sexually offensive behavior (e.g., NOJOS), as well as those specified by contracts (e.g., DHS).

8. The treatment plan of a youth should include the category of healing personal victimization when the youth has been a victim of sexual or physical abuse or neglect.

9. It is important that line workers be quickly and adequately assimilated into the program and that their understanding be sufficient to facilitate therapeutic endeavors.

10. Programs should plan recreational activities in advance.

11. Programs should be more scrupulous in fulfilling the requirements of the contract regarding the documentation of sending quarterly summaries.

12. Programs involved in the residential treatment of youthful sex offenders should use an electronic monitoring system.

13. Programs should specify rules for bedroom, bathroom, and interpersonal behaviors.

14. Each rule should have a clear, concise, and logical or natural consequences designated.

15. Group therapy should be the primary modality of aftercare.

16. Aftercare should extend at least 6 months after release from the program.

17. Programs should make a formal effort to track rearrest and recidivism.

18. Programs should update BCI and USSDS background checks annually.

19. Programs should hold therapists accountable for their experience and training by maintaining documentation of such in their personnel files.

REFERENCES

Able, G., Osborne, C. A., & Twigg, D. A. (1993). Sexual assault through the life span: Adult offenders with juvenile histories. In H. E. Barbaree, W. L. Marshall, & S. M. Hudson (Eds.), The juvenile sex offender (pp. 104-117). New York: Guilford.

American Psychiatric Association. (1994). Diagnostic and statistical manual IV. Washington, DC: Author.

Bala, N. & Schwartz, I. (1993). Legal responses to the juvenile sex offender. In H. E. Barbaree, W. L. Marshall, & S. M. Hudson (Eds.), The juvenile sex offender (pp. 25-43). New York: Guilford..

Barbaree, H. E., & Cortoni, F. A. (1993). Treatment of the juvenile sex offender within the criminal justice & mental health systems. In H. E. Barbaree, W. L. Marshall, & S. M. Hudson (Eds.), The juvenile sex offender (pp. 243-263). New York: Guilford..

Barbaree, H. E., Hudson, S. M., & Seto, M. C. 1993. Sexual assault in society: The role of the juvenile offender. In H. E. Barbaree, W. L. Marshall, & S. M. Hudson (Eds.) The Juvenile sex offender (pp. 1-18). New York: Guilford.

Becker, J. (1994) Offenders: Characteristics & treatment. The Future of Children, 4 (2), 176-197.

Becker, J. V., & Abel, G. G. (1983). Methodological and ethical issues in evaluating and treating adolescent sexual offenders. In E. M. Otey and G. D. Ryan (Eds.), Adolescent sex offenders: Issues in research and treatment (pp. 109-129). Washington, DC: U. S. Department of Health and Human Services.

Becker, J. V., Kaplan, M. S., Cunningham-Rathner, J., & Kavoussi, R. (1986). Characteristics of adolescent incest sexual perpetrators: Preliminary findings. Journal of Family Violence, 1(1), 85-97.

Becker, J. V., Kaplan, M. S., & Kavoussi, R. (1988) . Measuring the effectiveness of treatment for the aggressive adolescent sexual offender. Annals of the New York Academy of Sciences,528, 215-222.

Bell, J. B. (1994). Managing evaluation projects step by step. In J. S. Wholey, H. P. Hatry, & K. E. Newcomer (Eds.), Handbook of practical program evaluation (pp. 510-533). San Francisco: Jossey-Bass.

Berecochea, J. E., & Gibbs, J. B. (1991). Inmate classification: A correctional program that works? Evaluation Review, 15 (3), 333-363.

Campbell, D. T. (1969). Reforms as experiments. American Psychologist, 24,(4), 409-429.

Campbell, D. T. (1994). Retrospective and prospective on program impact assessment. Evaluation Practice, 15(3), 291-298.

Cantwell, H. B. (1988). Child sexual abuse: Very young perpetrators. Child Abuse and Neglect, 12, 579-582.

Cavanaugh-Johnson, T. (1989). Female child perpetrators: Children who molest other children. Child Abuse and Neglect, 13, 571-585.

Chen, H. (1994). Current trends and future directions in program evaluation. Evaluation Practice, 15, 229-238

Cronbach, L. J. (1982). Designing evaluations of educational and social programs. San Francisco: Jossey-Bass.

Dehar, M., Cassell, S., & Duignan, P. (1993). Formative and process evaluation of health promotion and disease prevention programs. Evaluation Review, 17(2), 204-220.

Department of Human Services Licensing. (1991). Core and categorical rules for treatment. Salt Lake City, UT: Author.

Division of Family Services/Division of Youth Corrections. (1995). Provider training: Medicaid enhancement for mental health services for youth in custody. Salt Lake City, UT: Author.

Dougher, M. J. (1995). Behavioral techniques to alter sexual arousal. In B. K. Schwartz & H. R. Cellini, (Eds.), The sex offender: Corrections, treatment, and legal practice (pp. 15-1 to 15-8). Kingston, NJ: Civic Research Institute.

Elliot, D. M., & Smiljanich, K. (1994). Sex offending among juveniles: Development and response. Journal of Pediatric Health Care, 8, 101-105.

Freeman-Longo, R. E., Bird S., Stevenson, W F., & Fiske, J. A. (1994). The nationwide survey of treatment programs and models serving abuse-reactive children and adolescent and adult sex offenders. Brandon, VT: Safer Society.

Gerdes, K. E., Gourley, M. M., & Cash, M. C. (1995). Assessing juvenile sex offenders to determine adequate levels of supervision. Child Abuse and Neglect, 19(8), 953-961.

Graves, R. E. (1993). Conceptualizing the youthful male sex offender: A meta-analytic examination of offender characteristics by offense type. Unpublished doctoral dissertation, Utah State University, Logan.

Gray, A. S., & Pithers, W. D. (1993). Relapse prevention with sexually aggressive adolescents and children: Expanding treatment and supervision. In H. E. Barbaree, W. L. Marshall, & S. M. Hudson (Eds.), The juvenile sex offender (pp. 289-319). New York: Guilford.

Green, R. (1995). Sex offender treatment program evaluation. In B. K. Schwartz & H. R. Cellini (Eds.), The sex offender: Corrections, treatment, and legal practice, (pp. 9-1 to 9-10). Kingston, NJ: Civic Research Institute.

Guarino-Chezzi, S., & Loughran, E. J. (1996). Balancing juvenile justice. New Brunswick, NJ: Transaction.

Hawks, R. (1995/96). PREDICTS RISK worksheet. Ogden, UT: Law and Human Behavior Institute.

Heinz, J. W., Gargaro, S., & Kelly, K. G. (1987). A model residential juvenile sex-offender treatment program: The Hennepin County Home School. Syracuse, NY: Safer Society .

Henggeler, S. W., Smith, B. H., & Schoenwald, S. K. (1993). Key theoretical and methodological issues in conducting treatment research in the juvenile justice system. Journal of Clinical Child Psychology, 23 (2), 143-150.

Hunter, M. (1990). Abused boys: The neglected victims of child abuse. Lexington, MA: Lexington Books.

Johnson, T. C. (1988). Child perpetrators--Children who molest other children: Preliminary findings. Child Abuse and Neglect, 12, 219-229.

Kahn, T. J., & Chambers, H. J. (1991). Assessing reoffense risk with juvenile sex offenders. Child Welfare, 70 (3), 333-345.

Knopp, F. H. (1982). Remedial intervention in adolescent sex offenses: Nine program descriptions. Orwell, VT: Safer Society.

Lakey, J. F. (1992). Myth information and bizarre beliefs of male juvenile sex offenders. Journal of Addictions and Offender Counseling, 13(1), 2-10.

Lane, S. (1991). The sexual abuse cycle. In G. Ryan & S. Lane (Eds.), Juvenile sexual offending: Causes, consequences, and correction (pp. 103-142). Lexington, MA: Lexington Books.

Leviton, L. C. (1994). Program theory and evaluation theory in community-based programs. Evaluation Practice, 15 (1), 89-92.

Lightfoot, L. O., & Barbaree, H. E. (1993). The relationship between substance use and abuse and sexual offending in adolescents. In H. E. Barbaree, W. L. Marshall, & S. M. Hudson, (Eds.), The juvenile sex offender (pp. 203-224). New York: Guilford.

Lipps, G., & Grant, P. R. (1990). A participatory method of assessing program implementation. Evaluation Review, 14 (4), 427-434.

Marlett, G. A., & Gordon, J. (1985). Relapse prevention: Maintenance strategies in the treatment of addictive behaviors. New York: Guilford.

McConaghy, M. N., Blaszczynski, A., Armstrong, M. S., & Kidson, W. (1989). Resistance to treatment of adolescent sex offenders. Archives of Sexual Behavior, 18 (2), 97-107.

Miner, M. H., & Crimmins, C. L. (1997). Adolescent sex offenders--Issues of etiology and risk factors. In B. K. Schwartz & H. R. Cellini (Eds.), The sex offender: New insights,

treatment, innovations, and legal developments (pp. 9-1 to 9-13). Kingston, NJ: Civic Research Institute.

Morain, C. (1994). When children molest children. American Medical News 37, (1), 13.

Muehlenhard, C. L., & Linton, M. A. (1987). Date rape and sexual aggression in dating situations: Incidence and risk factors. Journal of Counseling Psychology, 34, 186-196.

Muster, N. J. (1992). Treating the adolescent victim-turned-offender. Adolescence, 27 (106), 441-450.

National Task Force on Juvenile Sexual Offending (1988). The preliminary report from the National Task Force on Juvenile Sexual Offending. Juvenile and Family Court Journal, 39 (2).

National Task Force on Juvenile Sexual Offending. (1993). The revised report from the National Task Force on Juvenile Sexual Offfending, 1993, of the National Adolescent Perpetrator Network. Juvenile and Family Court Journal, 44, 1-120.

Network on Juveniles Offending Sexually (NOJOS). (1989). The Utah report on juvenile sex offenders. Utah: Author.

Network on Juveniles Offending Sexually (NOJOS). (1994). Juvenile sex offender specific protocols and standards manual. Salt Lake City, UT: Author.

Network on Juveniles Offending Sexually (NOJOS). (1996). Juvenile sex offender specific protocals and standards manual (2nd ed.). Salt Lake City, UT: Author.

Newcomer, K. E., Hatry, H. P., & Wholey, J. S. (1994). Meeting the need for practical evaluation approaches: An introduction. In J. S. Wholey,. H. P. Hatry, & K. E. Newcomer (Eds.), Handbook of practical program evaluation (pp.1-10). San Francisco: Jossey-Bass.

Nightingale, D. S., & Rossman, S. B. (1994). Managing field data collection from start to finish. In J. S. Wholey. H. P. Hatry, & K. E. Newcomer (Eds.), Handbook of practical program evaluation (pp. 350-373). San Francisco: Jossey-Bass.

Olsen, D H. (1983) Families. Beverly Hills, CA: Sage.

Openshaw, D. K., & Barlow, K. (1997). Recidivism rates of Level Six residential programs for youthful male sex offenders in the State of Utah. Unpublished manuscript.

Otey, E. M., & Ryan, G. D. (Eds.) (1983). Adolescent sex offenders: Issues in research and treatment. Rockville, MA: US Department of Health and Human Services.

Perry, G., & Orchard J. (1992). Assessment and treatment of adolescent sex offenders. Sarasota, FL: Professional Resource.

Pithers, W. D., & Cumming, G. F. (1995). Relapse prevention: A method for enhancing behavioral self-management and external supervision of the sexual aggressor. In B. K. Schwartz & H. R. Cellini (Eds.), The sex offender: corrections, treatment, and legal practice (pp. 20-1 to 20-32). Kingston, NJ.: Civic Research Institute.

Prentky, R. A., & Burgess, A. W. (1991). Hypothetical biological substrates of a fantasy-based drive mechnanism for repetive sexual aggression. In A. W. Burgess (Ed.), Rape and sexual assault III (pp. 235-256). New York: Garland.

Rasmussen, L. (1995). Factors related to recidivism among juvenile sexual offenders. Unpublished doctoral dissertation, University of Utah, Salt Lake City.

Rossi, P. H., & Freeman, H. E. (1985). Evaluation: A systematic approach. Beverly Hills, CA: Sage.

Rubinstein, M., Yeager, C., A., Goodstein, C., & Lewis, D. O. (1993). Sexually assaultive male juveniles: A follow-up. American Journal of Psychiatry, 150 (2), 262-265.

Ryan, G., Lane, S., Davis, J., & Isaac, C. (1987). Juvenile sex offenders: Development and correction. Child Abuse and Neglect, 11, 385-395.

Ryan, G., Miyoshi, T. J., Metzner, J. L., Krugman, R. D., & Fryer, G. E. (1996). Trends in a national sample of sexually abusive youth. Journal of the American Academy of Child and Adolescent Psychiatry, 35 (1), 17-21.

Sapp, A. D., & Vaughn, M. S. (1990) Juvenile sex offender treatment at state-operated correctional institutions. International Journal of Offender Therapy and Comparative Criminology, 34 (2), 131-146.

Saunders, E. B., & Awad, G. A. (1988). Assessment, management, and treatment planning for male adolescent sexual offenders. American Journal of Orthopsychiatry, 58 (4), 571-579.

Scheirer, M. A. (1994). Designing & using process evaluation. In J. S. Wholey, H. P. Hatry, & K. E. Newcomer (Eds.), Handbook of practical program evaluation (pp. 40-68). San Francisco: Jossey-Bass.

Schwartz, B. K., & Cellini, H. R. (Eds.). (1995). The sex offender: Corrections, treatment, and legal practice. Kingston, NJ: Civic Research Institute.

Sechrest, L. (1994). Program evaluation: Oh what it seemed to be! Evaluation Practice, 15(3), 359-365.

Sechrest L. & Figueredo, A. J. (1993) Program evaluation. Annual Review of Psychology, 44, 645-674.

Sefarbi, R. (1990). Admitters and deniers among adolescent sex offenders and their families: A preliminary study. American Journal of Orthopsychiatry, 60 (3), 460-465.

Silverman, M., Ricci, E. M., & Gunter, M. J. (1990). Strategies for increasing the rigor of qualitative methods in evaluation of health care programs. Evaluation Review, 14 (1), 57-74.

Smith, M. F. (1994). Evaluation: Review of the past, preview of the future. Evaluation Practice, 15 (3), 215-227.

Smith, R. C. (1995). Sex offender program planning and implementation. In B. K. Schwartz & H. R. Cellini (Eds.), The sex offender: Corrections, treatment, and legal practice (pp. 7-1 to 7-13). Kingston, NJ: Civic Research Institute.

Thomas, D. (1992). A special report on juvenile sex offenders. Pittsburg, PA: National Center for Juvenile Justice.

Utah Governor's Council on Juvenile Sex Offenders. (1990). Comprehensive plan for juvenile sex offenders: Preliminary report. Salt Lake City, UT: Author.

Unrau, Y. A. (1993). Expanding the role of program evaluation in social welfare policy analysis. Evaluation Review, 17(6), 653-662.

Ward, T., & Hudson, S. M. (1996). Relapse prevention: A critical analysis. Sexual abuse: A journal of research and treatment, 8 (3), 177-200.

Weiss, C. H. (1993). Where politics and evaluation research meet. Evaluation Practice, 14(1), 93-109.

Western Region Division Child and Family Services (1996). DST provider (Level 6 NOJOS): Quality assurance project. Provo, UT: Author.

White, J. W., & Koss, M. P. (1993). Adolescent sexual aggression within heterosexual relationships: Prevalence, characteristics, and causes. In H. E. Barbaree, W. L. Marshall, & S. M. Hudson (Eds.), The juvenile sex offender (pp.182-201). New York: Guilford.

Winrott, M. R. (1996). Juvenile sexual aggression: A critical review. Denver: University of Colorado, Center for the Study and Prevention of Violence.

Worthen, B. R.,& Saunders, J. R. (1987). Educational evaluation. White Plains, NY: Longman.

Yochelson, S., & Samenow, S. (1976). The criminal personality: Vol. 1. A profile for change. New York: Random House.

APPENDICES

Appendix A

Juvenile Sex Offender Provider Program Implementation Tool

PART 1:

CASE FILE REVIEWS

(1 instrument per case file)

CLINICAL STAFF-ASSISTED

Target Area 1: TARGET POPULATION					
Item No.	Item	1/0	Wt	=	Comments
1a1	Youth used a weapon to commit offense.		10.2		
1a2	Youth inflicted discernible physical harm on victim.		7.8		
1a3	Youth has escalated the frequency, duration, or type of aggression involved in offense.		5		
1a4	Youth used force to coerce victim, such as threats, tricks, or physical confinement.		5.2		
1a5	Youth has multiple child victims.		3.8		
1a6	Youth has used grooming behavior (offender stalked, preplanned the offense, or provided the victim with special treatment such as bribes, rewards, or games).		2.4		
1a7	Youth repeated sexual assault cycle of previous offense.		3		
1a8	Youth has had at least one nonconsensual peer victim.		2.8		
1b1	Youth had prior history of sex offender specific treatment and has continued to reoffend.		7.8		
1b2	Youth cannot be adequately supervised because the prior history of sex offender specific treatment and has continued to reoffend.		3.8		
1b3	Youth has documented behavioral and emotional problems that interfere with functioning in a wide variety of contexts (e. g., school, home, with peers).		3.8		

Target Area 1: TARGET POPULATION			
Item No.	Item	✓	Comments
	Youth has a diagnosis of the following:		
1c1	ADHD		
1c2	Adjustment Disorder		
1c3	Anxiety Disorder		
1c4	Conduct Disorder		
1c5	Elimination Disorder		
1c6	Impulse Disorder		
1c7	Learning Disorder		
1c8	Mental Retardation		
1c9	Mood Disorder		
1c10	Personality Disorder		
1c11	Schizophrenia/Psychosis		
1c12	Substance Related Disorder		
1c13	Seizure Disorder		
1c14	Sexual Disorder		

Target Area 1: TARGET POPULATION				
Item No.	Item	Yes (1)	No (0)	Comments
1d1	Youth had a Level A assessment in chart.			
1d2	Youth had either a Level B or Level C assessment in chart.			
1e1	Youth was a victim of physical abuse.			
1e2	Youth was a victim of sexual abuse.			
1e3	Youth was a victim of neglect.			
1e4	Youth's perpetrator was father or stepfather.			
1e5	Youth's perpetrator was mother or stepmother.			

Target Area 1: TARGET POPULATION				
Item No.	Item	Yes (1)	No (0)	Comments
1e6	Youth's perpetrator was a sibling.			
1e7	Youth's perpetrator was an acquaintance.			
1e8	Youth's perpetrator was a stranger.			
1e6	Youth's perpetrator was a sibling.			
1e7	Youth's perpetrator was an acquaintance.			
1e8	Youth's perpetrator was a stranger.			
1f1	Youthful victims included female and not male 3 or more years younger than self only.			
1f2	Youthful victims included male and not female 3 or more years younger than self only.			
1f3	Youth victimized both female and males 3 or more years younger than self.			
1f4	Youth victimized family members only.			
1f5	Youth victimized acquaintances only.			
1f6	Youth victimized strangers only.			
1f7	Youth victimized a combination of family members, acquaintances, and strangers.			
1f8	Youth victimized person 3 or more years older.			
1g1	Youth has had one other residential JSO placement.			
1g2	Youth has had two other residential JSO placements.			
1g3	Youth has had three or more other residential JSO placements.			

TARGET AREA 3: TREATMENT CONSTELLATION

Item No.	Item	Yes (1)	No (0)	Comments
3a1	Mental health treatment plan was signed by youth.			
3a2	Skills development treatment plan was signed by the youth.			
3c1	Treatment plan contains objective of remediating cognitive distortions.			
3c2	Treatment plan contains objective of reducing deviant arousal.			
3c3	Treatment plan contains objective of relapse prevention.			
3c4	Treatment plan contains objective of healing personal victimization.			
3c5	Treatment plan contains objective of increasing interpersonal competency.			
3c6	Treatment plan contains objective of increasing personal competency.			
3c7	Treatment plan contains objective of decreasing exploitative behaviors.			
3d1	Client file contains a mental health treatment plan.			
3d2	Client file contains a skills development treatment plan.			
3d3	Mental health treatment plan contains the signature of a licensed practitioner (psychiatrist, psychologist, marriage and family therapist, professional counselor, advanced practice RN, or clinical social worker).			
3d4	Mental Health Treatment Plan contains the credentials of the individuals who will furnish the services.			

TARGET AREA 3: TREATMENT CONSTELLATION				
Item No.	Item	Yes (1)	No (0)	Comments
3d5	Mental health treatment plan contains a statement of disability.			
3d6	Mental health treatment plan specifies how long treatment is expected to continue.			
3d7	Mental health treatment goals specifies measures to evaluate whether objectives are met.			
3d8	Skills development treatment plan is signed by a licensed practitioner, licensed certified social worker, social service worker, RN, LPN, or other person certified to provide Skills Development Services.			
3d9	Skills development treatment plan contains the credentials of the individuals who will furnish the services.			
3d11	Skills development treatment plan specifies how long treatment is expected to continue.			
3d12	Skills development treatment goals specifies measures to evaluate whether objectives are met.			
3f1	Mental health treatment plan includes family therapy sessions, unless it is documented that family is unavailable or unwilling to participate in treatment.			
3g1	Quarterly summary of treatment plan was sent to DCFS/DYC. (Note on bottom of treatment plan may indicate this.)			
3h1	Group therapy is noted in progress notes with the date and time spent.			

TARGET AREA 3: TREATMENT CONSTELLATION

Item No.	Item	Yes (1)	No (0)	Comments
3h2	The number of clients in the session is documented in progress notes.			
3h3	Progress on treatment goals during group sessions are to be noted by the key words from the treatment plan.			
3i1	Individual therapy is noted in progress notes with date and time spent.			
3i2	Progress on treatment goals during individual sessions are to be noted by the key words from the treatment plan.			

PART II:

WRITTEN MATERIAL REVIEW

(1 instrument per program)

ADMINISTRATIVE/CLINICAL STAFF-ASSISTED

TARGET AREA 2: INTAKE PROCEDURE AND CRITERIA				
Item No.	Item	Yes	No	Comments
	Written intake criteria include the following information:			
2a1	Gender of youth.			
2a2	Range of ages that the program serves.			
2a3	DSM IV categories for which program will not work.			
2a4	Cognitive capabilities of youth that are or are not acceptable for admission.			
2a5	Level of parental and/or community support required for acceptance into the program.			
2a6	Judicial and legal requirements for admission into the program..			
2a7	Nonsexual criminal or antisocial behaviors that do not stop admission such as fire setting, assault, and so forth			
2b1	Program has written intake procedure.			
2b2	Program have written copies of program procedures and goals available to give youths and parents/guardians.			

TARGET AREA 3: TREATMENT CONSTELLATION				
Item No.	Item	Yes (1)	No (2)	Comments
3e1	Program has therapy master manual or manual describing therapeutic protocal.			
3f2	Family therapy sessions are JSO specific.			
3h4	Sex offender specific group therapy occurs at least two times per week.			

TARGET AREA 3: TREATMENT CONSTELLATION				
Item No.	Item	Yes (1)	No (2)	Comments
3h5	Group therapy uses behavioral strategies to help reduce deviant arousal.			
3h6	Group therapy includes the identification and increased understanding of individual factors that contribute to offending cycle.			
3h7	Group therapy includes the development of a relapse prevention plan.			
3h8	Sex education issues, including AIDS, are integrated with group therapy.			
3h9	Sex education issues, including STDs, are integrated with group therapy.			
3i3	Individual therapy occurs at least two times weekly.			
3i4	Individual therapy serve as an adjunct to group therapy.			
3j1	Program arranges for adjunct therapies as needed, including diagnostic information, psychopharmacological management, substance abuse counseling, psychiatric services, and so forth.			
3j2	Program maintains documentation of medication administered to youth.			
3n1	Client staffings are held weekly.			
3n2	DCFS and DYC are invited to at least two staffings per month.			

TARGET AREA 4: SUPERVISION				
Item No.	Item	Yes (1)	No (0)	Comments
4a1	Program provides 24 hr/day awake supervision.			
4a2	Program provides a 1:3 staff to client ratio during day hours.			
4d1	Program has a policy/procedures manual.			
4d2	Program has a written behavioral management system.			
4d3	The behavioral management system defines acceptable staff responses to inappropriate behaviors.			
4d4	The behavioral management system defines appropriate and inappropriate behaviors of consumers.			
4d5	The behavior management system defines the use of physical restraint as the temporary use of passive physical restraint to protect the consumer, other persons, or property from harm. There is no implication of humiliation to the youth.			
4d6	Program have levels with entrance and exit behaviors.			
4d7	Program has a process which youth and staff communicate progress or lack of progress in level.			
4d8	Program document youth's progress or lack of progress in levels.			
4e1	Program has written rules about bedroom behaviors. (Copy rules)			
4e2	Program has written rules about bathroom behaviors. (Copy rules)			

TARGET AREA 4: SUPERVISION				
Item No.	Item	Yes (1)	No (0)	Comments
4e3	Program have written rules about interpersonal behaviors and boundaries. (Copy rules)			
4e4	Program has a written procedure regarding room assignment.			
4f1	Program has a written policy stating the program violation process, including the consequences for violating a rule or the consequences for failing to comply with treatment demands. (Copy program violation process)			
4f2	Program has written policy regarding how violations are determined to be true.			
4f3	Program has written policy regarding the reporting of violations to caseworkers, police, court, and other staff.			
4f4	Program has a process where staff members report infractions of rules to each other.			
4f5	Program document its attempts to carry out its consequences.			
4f6	Program has written grievance procedure for youths and parents.			
4f7	In event that youth is terminated from program, therapists make written recommendations for alternative programming to DCFS/DYC case managers.			
4g1	Program has written supervision requirements of parents during home visits.			

TARGET AREA 4: SUPERVISION				
Item No.	Item	Yes (1)	No (0)	Comments
4g2	Program document parent's/custodian's home supervision training.			

TARGET AREA 5: AFTERCARE				
Item No.	Item	Yes (1)	No (0)	Comments
5a1	The program can provide or arrange for therapeutic intervention with youth under DCFS custody but living at home or in other community programs.			
5a2	Program has Level Four (JSO Group, Proctor, Structured Homes) available within its agency or allied agencies.			
5a3	Program has Level Three (JSO Specific Day Treatment) available within its agency or allied agencies.			
5a4	Program has Level Two (JSO Specific Outpatient) available within its agency or allied agencies.			
5a5	Program provides an aftercare plan for the youth which includes individual therapy.			
5a6	Program provides an aftercare plan for the youth that includes group treatment.			
5a7	Program provides an aftercare plan for the youth that includes family or multifamily therapy.			
5a8	Group or parent group therapy is the primary modality of aftercare treatment.			
5a9	Aftercare services extend at least 6 months after release from the program.			

TARGET AREA 5: AFTERCARE				
Item No.	Item	Yes (1)	No (0)	Comments
5b1	Program maintains a copy of the youth's aftercare plan.			
5b2	Aftercare services documented in client's individual file.			
5b3	A copy of the aftercare plan attached with the youth's discharge summary from the facility.			
5b4	The aftercare plan been jointly defined and agreed on by program treatment staff and DCFS staff.			
5c1	Program tracks sex offense rearrest records of former residents.			
5c2	Program tracks former clients reoffending behaviors.			

TARGET AREA 6: STAFF TRAINING AND QUALIFICATIONS				
Item No.	Item	Yes	No	Comments
6a1	Program keeps BCI checks on therapy staff updated yearly.			
6a2	Program keeps USSDS checks on therapy staff updated yearly.			
6a3	Program maintains copy of current licenses of therapy staff.			
6a4	Program maintains documentation of their supervised clinical experience working with juvenile sexual offenders.			
6a5	Therapy staff members have signed a DHS Code of Conduct.			
6b1	Program keeps BCI checks on line staff updated yearly.			
6b2	Program keeps USSDS checks on line staff updated yearly.			

TARGET AREA 6: STAFF TRAINING AND QUALIFICATIONS				
Item No.	Item	Yes	No	Comments
6b3	Line staff have documented at least 20 hr of pre-service training plus 2 hr of basic first aid and CPR training.			
6b4	Program maintains documentation of training received by staff, including dates of training, hr of training, subject, and name of trainer or other resources used to provide the training.			
6b5	Line staff members have signed a DHS Code of Conduct.			
	The training of line staff includes the following:			
6c1	DHS Contractor Code of Conduct			
6c2	Adolescent behavior and development			
6c3	Behavior management and discipline methods			
6c4	First aid and emergency procedures			
6c5	Parenting skills			
6c6	The goals of juvenile sex offending treatment			
6c7	Modalities of treatment used by the program			
6c8	The supervision of juveniles offending sexually			
6c9	The program's policies and procedures			
6c10	Court procedures (at least one person)			
6c11	Applicable federal entitlement requirements (at least one person)			
6c12	An orientation to the provider's contract (at least one person)			

LINE STAFF-ASSISTED

TARGET AREA 3: TREATMENT CONSTELLATION				
Item No.	Item	Yes (1)	No (0)	Comments
3k1	Life skills training/day treatment occurs at least 3 hr per day.			
3k2	Group and individual work in SDS focuses on mastery social skills peculiar to this population as well as traditional independent living skills.			
3k3	Documentation of SDS services includes daily entry that includes the date, number of hr of service, and a brief description of the service.			
3l1	Recreational activities occur at least two times per week.			
3l2	Recreational activities planned in advance.			

TARGET AREA 3: TREATMENT CONSTELLATION			
Item No.	Item	Number	Comments
3m1	How many youth are in each of the following programs?		
3m2	Youth in Custody (YIC)?		
3m3	Special education?		
3m4	Not accredited?		
3m5	How many youths are enrolled in the treatment program?		

PART III:

OBSERVATIONAL REVIEW

(One instrument per program)

ADMINISTRATIVE/CLINICAL STAFF-ASSISTED

TARGET AREA 4: SUPERVISION				
Item No.	Item	Yes (1)	No (0)	Comments
4b1	Program provides indoor space for free and informal activities of consumers.			
4b2	Program has space that serves as an administrative office for records, secretarial work and bookkeeping.			
4b3	Program has space designated for private and group counseling sessions.			
4b4	No more than four youth share a bedroom, and there are at least 60 square feet per occupant. (On this question, ask to see in writing or by measurement the square footage of the bedrooms.)			
4b5	Single resident bedrooms have at least 80 square feet.			
4b6	Sleeping areas have a source of natural light.			
4b7	Sleeping areas are ventilated by mechanical means or equipped with a screened window that can be opened.			
4b8	Beds are solidly constructed (no portable beds).			
4b9	Linens are changed weekly.			
4b10	There is least one toilet, one lavatory, one tub or shower for each six residents.			

TARGET AREA 4: SUPERVISION				
Item No.	Item	Yes (1)	No (0)	Comments
4b11	The toilets and baths or showers allow for individual privacy, unless consumers require assistance.			
4b12	Bathrooms are to be so placed as to allow access without disturbing other residents during sleeping hours.			
4b13	Bathrooms are ventilated by mechanical means or equipped with openable screened windows.			
4c1	Program has physical monitoring system or motion sensor that covers patient areas.			
4c2	School is self-contained within program facility.			

PART IV:

INTERVIEWS

(One per interviewee)

ADMINISTRATIVE/CLINICAL STAFF

TARGET AREA 2: INTAKE PROCEDURE AND CRITERIA				
Item No.	Item	Yes (1)	No (0)	Comments
2b3	(Ask: When someone calls to refer a youth, who handles the call?) Program has intake coordinator or person responsible for coordinating intake.			

LINE STAFF

TARGET AREA 3: TREATMENT CONSTELLATION		
Item No.	Item	Number
	(Ask: Tell me about what the youth are working on in therapy. What are they doing to work on it?)	
3b1	Number of treatment words identified	
3b2	Number of treatment goals identified	
3b3	Number of treatment categories identified	

TARGET AREA 4: SUPERVISION				
Item No.	Item	Yes (1)	No (0)	Comments
4c3	(Ask: "Tell me about what the staff are required to do during night." "What are some of the things they do to maintain client safety from abuse from other clients?") Program has awake night staff that monitors residents both randomly and at frequently planned intervals throughout the night.			

TARGET AREA 4: SUPERVISION		
Item No.	Item	Number
	(Ask: Please tell me one or two rules that you consider to be most important for the youths to follow in the bedroom.)	
4e8	Number of matches between program rules about bedroom behavior and line worker.	

TARGET AREA 4: SUPERVISION

Item No.	Item	Number
	(Ask: Please tell me one or two rules that you consider to be most important for the youths to follow in the bathroom.)	
4e9	Number of matches between program rules about bathroom behaviors and line worker	
	(Ask: Please tell me one or two rules that you consider to be most important for the youths to follow in order to get along with each other).	
4e10	Number of matches between program rules about interpersonal behaviors and line worker	

Data Entry Sheet for Items 3b1-3b3

I. Treatment Goals

Treatment Category	Hits	Words/Phrases
Cognitive Distortions		
Deviant Arousal		
Relapse Prevention		
Personal Victimization		
Interpersonal Competency		
Personal Competency		
Exploitative Behaviors		

Data Entry Sheet for Items 4e8 to 4e10

Hit	Bedroom Behaviors	Hit	Bathroom Behaviors	Hit	Interpersonal Behaviors

Treatment Goals

YOUTH

TARGET AREA !: TARGET POPULATION		
Item No.	Item	Number
1h1	How long have you been here? (in months)	
1h2	How many other residential sex abuse programs have you been in?	
1h3	How many outpatient sex abuse programs have you been in?	

TARGET AREA 3: TREATMENT CONSTELLATION		
Item No.	Item	Number
	(Ask: Tell me about what you are working on in therapy. What are you doing to work on it?)	
3a3	Number of treatment words identified.	
3a4	Number of treatment goals identified.	
3a5	Number of treatment dimensions identified.	

TARGET AREA 4: SUPERVISION		
Item No.	Item	Number
	(Ask: Please list one or two rules that you consider to be most important for the youths to follow in the bedroom.)	
4e11	Number of matches between youth and primary line worker's response.	
4e12	Number of matches between youth and list of program rules for bedroom behavior.	

TARGET AREA 4: SUPERVISION		
Item No.	Item	Number
	(Ask: Please list one or two rules that you consider to be most important for the youths to follow in the bathroom.)	
4e13	Number of matches between youth and primary line worker's response.	
4e14	Number of matches between youth and program rules for bathroom behaviors.	

TARGET AREA 4: SUPERVISION		
Item No.	Item	Number
	(Ask: Please list one or two rules that you consider to be most important for the youths to get along with each other).	
4e15	Number of matches between youth and primary line worker's response.	
4e16	Number of matches between youth and program rules about interpersonal behaviors.	

TARGET AREA 4: SUPERVISION		
Item No.	Item	Number
4e17	Number of matches with other youth's responses on "bedroom rules."	
4e18	Number of matches with other youth's responses on "bathroom behaviors."	
4e19	Number of matches with other youth's responses on "interpersonal behaviors."	

Data Entry Sheet for Items 3a1-3a3

I. Treatment Goals

Treatment Category	Hits	Words/Phrases
Cognitive Distortions		
Deviant Arousal		
Relapse Prevention		
Personal Victimization		
Interpersonal Competency		
Personal Competency		
Exploitative Behaviors		

Data Entry Sheet for Items 4e11 to 4e16

Hit	Bedroom Behaviors	Hit	Bathroom Behaviors	Hit	Interpersonal Behaviors

Treatment Goals

DATA SCORING GUIDE

SCORING INSTRUCTIONS FOR CLIENT FILE ITEMS

All "Yes" responses are marked with a 1 under the Yes column. All "No" responses are marked with a 0 under the "no" column.

Administrative/Clinical Staff Assisted

Target Area 1: TARGET POPULATION			
Items	Data Sources	Purpose	Scoring Instructions
1a	Assessments in individual client files	To determine if program serves juveniles who present severe risk to reoffend within the community.	Under the Column "1/0", data are recorded as follows: A "1" indicates that the youth had that characteristic; a "0" indicates that the youth did not have that characteristic. Under the Column "Wt", the mean weights assigned to the particular characteristic by a panel of experts is recorded. To get the score, multiply the 1/0 and Wt columns of each item. Place the answer under the "=" column.
1b	Assessments in individual client files	To determine if the program serves juveniles who have a need to be in nonsecure line treatment.	Follow instructions for question 1a

Target Area 1: TARGET POPULATION			
Items	Data Sources	Purpose	Scoring Instructions
1d	Assessments in individual client files	This question has two purposes. The first purpose is to assess the mental health problems of the population with which the program deals with. The second purpose is to check to see if the program is accepting youth who are candidates for a Level Seven program. Youth with severe mental illness are not candidates for Level Six programs.	Mental health Information should be in the Level B or C assessment and in the Intake assessment. Check the applicable mental health issues listed in the assessments.

Target Area 1: TARGET POPULATION			
Items	Data Sources	Purpose	Scoring Instructions
1e	Assessments in individual client files	To determine if proper administrative practices are being followed in identifying the population.	If staff member can show evaluator the assessments in the client file, mark "yes." Otherwise, "no."
1f	Assessments in individual client files; progress notes; therapist	To determine profile of youths' victimization experiences.	If therapist is aware of victimization experience or experience is recorded in assessment or progress notes, mark "yes." Otherwise, "no."
1g	Assessments in individual client files; progress notes; therapist	To determine profile of youths' offense experiences.	If therapist is aware of offense experience or experience is recorded in assessment or progress notes, mark "yes." Otherwise, "no."

Target Area 3: TREATMENT CONSTELLATION			
Items	Data Sources	Purpose	Scoring Instructions
3a	Either a mental health or a SDS treatment plan that is signed by the youth.	To determine if youth have signed their treatment plan.	If information is in file and properly rendered, mark "yes." Otherwise, mark "no."

Target Area 3: TREATMENT CONSTELLATION			
Items	Data Sources	Purpose	Scoring Instructions
3c	Written treatment plan	To determine the extent to which the treatment goals for the youth meet the minimum requirements of National Task Force of Juvenile Sex Offenders (1993) and NOJOS (1996).	If information is in file and properly rendered, mark "yes." Otherwise, mark "no."
3d	Written treatment plan	To determine the extent of the program's compliance with Medicaid treatment planning procedures.	If information is in file and properly rendered, mark "yes." Otherwise, mark "no."
3f	Written treatment plan	To determine if family therapy meets contractual and NOJOS requirements.	If information is in file and properly rendered, mark "yes." Otherwise, mark "no."
3g	Note at bottom of treatment plan, and so forth	To determine if a quarterly summary of treatment plan is sent to DCFS or DYC.	If information is in file and properly rendered, mark "yes." Otherwise, mark "no."
3h	Client or group treatment file	To determine if group therapy meets NOJOS and DHS Contract requirements.	If information is in file and properly rendered (with credentialed signature), mark "yes." Otherwise, mark "no."

TARGET AREA 3: TREATMENT CONSTELLATION			
Items	Data Sources	Purpose	Scoring Instructions
3i	Client or group treatment file	To determine if individual therapy meets NOJOS and DHS Contract requirements.	If information is in file and properly rendered (with credentialed signature), mark "yes." Otherwise, mark "no."

SCORING INSTRUCTIONS FOR WRITTEN MATERIAL ITEMS

Written material items include data from written materials are collected from such items as manuals, program brochures, personnel files, training logs, Request for Proposals (RFP's), medical logs, time logs, and so forth The interviewer will ask the administrative staff member to show the interviewer where to find the information. The interviewer must observe the information as being there, rather than taking the interviewee's word.

Administrative/Clinical Staff Assisted

Target Area 2: INTAKE PROCEDURE AND CRITERIA			
Items	Data Sources	Purpose	Scoring Instructions
2d	Written intake criteria in a program manual	To determine the extent of the comprehensiveness of program's written intake criteria.	If staff member can show evaluator written intake criteria, mark "yes". Otherwise, mark "no".
2e	Written intake criteria in a program manual	To determine if program has available written intake procedures that can be distributed to youth and their parents.	If staff member can show evaluator written intake procedures that can be given to youth and parents, mark "yes". Otherwise, mark "no".

TARGET AREA 3: TREATMENT CONSTELLATION			
Items	Data Sources	Purpose	Scoring Instructions
3e	Master Therapy Manual	To determine if the program have a master therapy manual.	If therapist can produce a Master Therapy Manual, mark "yes". Otherwise, mark "no".
3f	Master Therapy Manual Family therapy curriculum and materials	To determine the extent to which family therapy meet contractual and NOJOS requirements.	If family therapy materials or instructions deal with cutting through the denial of this group, mark "yes". Otherwise, mark "no".

TARGET AREA 3: TREATMENT CONSTELLATION			
Items	Data Sources	Purpose	Scoring Instructions
3h	Master Therapy Manual Group therapy curriculum and materials Client files	To determine the extent to which group therapy processes meet contractual and NOJOS requirements.	If therapist can show evaluator that the information requested by survey exists or is true, mark "yes". Otherwise, mark "no".
3i	Master Therapy Manual Individual therapy curriculum and materials Client files	To determine the extent to which individual therapy meets contractual and NOJOS requirements.	If therapist can show evaluator that the information requested by survey exists or is true, mark "yes". Otherwise, mark "no".
3j	Medical logs or other pertinent logs	To determine the extent to which the provision of adjunct therapy modalities meets contractual and NOJOS requirements.	If therapist can show evaluator that the information requested by survey exists or is true, mark "yes". Otherwise, mark "no".
3n	Client files or staffing logs	To determine the extent to which client staffings meet contractual requirements.	If therapist can show evaluator that the information requested by survey exists or is true, mark "yes". Otherwise, mark "no".

Target Area 4: SUPERVISION			
Items	Data Sources	Purpose	Scoring Instructions
4a	Staff logs and schedules	To determine if staff to client ratios conform with contractual requirements.	If staff member can show evaluator that the required number of staff are on duty at the right time, mark "yes". Otherwise, mark "no".
4d	RFPS Bulletin boards Manuals	To determine if the program has a written supervisory structure (system) that conforms with contractual requirements.	If the staff member can show evaluator the element of supervisory structure that are requested, mark "yes". Otherwise, mark "no".

Target Area 4: SUPERVISION			
Items	Data Sources	Purpose	Scoring Instructions
4e	Manuals	To determine if program rules defined in a way that protect youth and the public.	If staff member can show evaluator the citations in manuals or other written material that define the elements of program rules requested, mark "yes". Otherwise, mark "no".
4f	Manuals Incident reports Case files	To determine if program's violation process protects youth and the public.	If the staff member can show evaluator the written policies and documentation requested, mark "yes". Otherwise, mark "no".
4g	Manuals	To determine if the program has written grievance procedure for youth and parents.	If staff member can show evaluator a written grievance procedure, mark "yes". Otherwise, mark "no".
4h	Manuals Closed case files	To determine if recommendations for alternative programming are given to DCFS or DYC case manger when a client is terminated..	If staff member can show evaluator an example where a recommendation of alternative programming was documented and submitted to DCFS or DYC, mark "yes". Otherwise, mark "no".
4j	Manuals Parent handbook Youth handbook	To determine if the rules about home visits that designed to inhibit further offending behaviors.	If staff member can show evaluator written rules about home visits, mark "yes". Otherwise, mark "no".

Target Area 5: AFTERCARE			
Items	Data Sources	Purpose	Scoring Instructions
5a	Structure/Systems Manual	To determine the extent of the "continuum of care" concept does the program employs in planning for aftercare.	If staff member can show evaluator citations of policies and procedures that support the elements of "continuum of care" requested, mark "yes". Otherwise, mark "no".

Target Area 5: AFTERCARE			
Items	Data Sources	Purpose	Scoring Instructions
5b	Closed client files	To determine the extent to which the program documents the aftercare plan.	If staff member can show evaluator an example of which a former client was referred for aftercare and the elements requested on the survey were followed, mark "yes". Otherwise, mark "no".
5c	Management Information System	To determine the extent of the program's involvement in monitoring their efficacy through recidivism tracking.	If staff member can show evaluator data that have been collected on former clients, mark "yes". Otherwise, mark "no".

Target Area 6: STAFF TRAINING AND QUALIFICATIONS			
Items	Data Sources	Purpose	Scoring Instructions
6a	Personnel files	To determine the extent to which the therapists employed by program are qualified as sex offender- specific therapists.	If staff member can show evaluator that the documentation requested by the survey exists in the personnel files, mark "yes". Otherwise, mark "no" . The statement should be true about all of the files in order to receive a "yes" response. If it is true of only some of the files, mark "no" and note it in the comment s block.

Target Area 6: STAFF TRAINING AND QUALIFICATIONS			
Items	Data Sources	Purpose	Scoring Instructions
6b	Personnel files	To determine the extent to which the line staff employed by programed are qualified as sex offender specific staff.	If staff member can show evaluator that the documentation requested by the survey exists in the personnel files, mark "yes". Otherwise, mark "no" . The statement should be true about all of the files in order to receive a "yes" response. If it is true of only some of the files, mark "no" and note discrepancies in comment s block.
6a	Personnel files	To determine the extent to which the therapists employed by program are qualified as sex offender specific therapists.	If staff member can show evaluator that the documentation requested by the survey exists in the personnel files, mark "yes". Otherwise, mark "no" . The statement should be true about all of the files in order to receive a "yes" response. If it is true of only some of the files, mark "no" and note it in the comments block.
6b	Personnel files	To determine the extent to which the line staff employed by programed are qualified as sex offender specific staff.	If staff member can show evaluator that the documentation requested by the survey exists in the personnel files, mark "yes". Otherwise, mark "no" . The statement should be true about all of the files in order to receive a "yes" response. If it is true of only some of the files, mark "no" and note discrepancies in comment s block.

Target Area 6: STAFF TRAINING AND QUALIFICATIONS			
Items	Data Sources	Purpose	Scoring Instructions
6c	Personnel files Training logs	To determine the extent to which the line staff employed by program have been trained as sex offender specific staff.	If staff member can show evaluator that the documentation requested by the survey exists in the personnel files or training logs, mark "yes". Otherwise, mark "no". Some of the questionsdo not require everyone to be trained in that area. Ascertain that someone has had training in those areas, and then check the remaining personnel files or training logs to ascertain that the other training has been done. If it hasn't been done as specified, mark "no" and note discrepancies in comment block.

Line Staff Assisted

TARGET AREA 3: TREATMENT CONSTELLATION			
Items	Data Sources	Purpose	Scoring Instructions
3k	SDS log or written schedule	To determine the extent to which life skills training/day treatment meets contractual and NOJOS requirements.	If line staff can show evaluator documentation verifying the documentation requested, mark "yes". Otherwise, mark "no".
3l	SDS log or written schedule	To determine the extent to which recreational activities meet contractual and NOJOS requirements.	If line staff can show evaluator documentation verifying the documentation requested, mark "yes". Otherwise, mark "no".

TARGET AREA 3: TREATMENT CONSTELLATION			
Items	Data Sources	Purpose	Scoring Instructions
3m	Accredation document	To determine the nature of youth's educational placements.	Mark the numbers of youth that are enrolled in each of the programs.

SCORING INSTRUCTIONS FOR OBSERVATIONAL DATA

Observational items require the evaluator to tour the physical spaces within the building and record observations. It is important to list specific findings in the comment section in order to provide feedback to the program and to check for reliability concerns.

Target Area 2: INTAKE PROCEDURE AND CRITERIA			
Items	Data Sources	Purpose	Scoring Instructions
4b	Observation	To determine the extent to which the facility's composition complies with contractual requirements.	If observer notes the requirement is met, mark "yes". If there are any questionable observations or if the requirement is not met, mark "no" and record comments to provide feedback to evaluator and the program.
4c	Observation	To determine the extent to which the program's monitoring system meet good practice standards.	If observer notes the requirement is met, mark "yes". If there are any questionable observations or if the requirement is not met, mark "no" and record comments to provide feedback to evaluator and the program.

SCORING INSTRUCTIONS FOR INTERVIEW DATA

Interview data are qualitative, and require the scorer to match the response with preset criteria. Interviewer should audio record interviews which will later be transcribed and matched against preset criteria.

Line Staff

TARGET AREA 3: TREATMENT CONSTELLATION			
Items	Data Sources	Purpose	Scoring Instructions
3b	Line staff interviews	To determine the extent to which line staff understand the goals and processes of youth's treatment plans.	Audio record and transcribe interview with line staff. Identify matches with word processor program. Highlight matches. Visually check to determine if match is in proper context. Under column heading "Number", list a frequency count. The number of treatment words refers to a frequency count of the words "hits" between the response and the Qualitative Summary of Treatment Concepts. The number of treatment goals refers to the number of goals the respondent gives. The number of categories refers to how many of the six treatment dimensions identified in the Qualitative Summary are tapped by the response.

TARGET AREA 4: SUPERVISION			
Items	Data Sources	Purpose	Scoring Instructions
4e	Interview with line staff	To determine the extent to which program rules defined in a way that protect youth and the public.	Audio record and transcribe interview with line staff. Make a copy of bedroom, bathroom, and interpersonal behaviors from program materials defining rules. Highlight the matches between written materials and the interview on the transcribed interview.Count the frequency and enter in "number" column.

Youth

INTRODUCTION		
Item No.	Purpose	Scoring Instructions
01-03	To get a profile of youth in program.	Audio record youth's response. Scorer will list the number on the data collection form.
04-05	To measure youth's subjective response to program.	Audio record youth's response. Scorer will list rating on data collection form.

TARGET AREA 3: TREATMENT CONSTELLATION			
Items	Data Sources	Purpose	Scoring Instructions
3b	Youth Interviews	To determine the extent to which youth understand the goals and processes of their treatment plans	Audio record and transcribe interview with youth. Identify matches with word processor program. Highlight matches. Visually check to determine if match is in proper context. Under column heading "Number", list a frequency count. The number of treatment words refers to a frequency count of the words "hits" between the response and the Qualitative Summary of Treatment Concepts. The number of treatment goals refers to the number of goals the respondent gives. The number of categories refers to how many of the six treament dimensions identified in the Qualitiative Summary are tapped by the response.

TARGET AREA 4: SUPERVISION			
Items	Data Sources	Purpose	Scoring Instructions
4e	Interview with youth	To determine the extent to which program rules defined in a way that protect youth and the public.	Audio record and transcribe interview with youth. Make a copy of bedroom, bathroom, and interpersonal behaviors from program materials defining rules. Highlight the matches between written materials and the interview on the transcribed interview.Count the frequency and enter in "number" column.

TARGET AREA 4: SUPERVISION			
Items	Data Sources	Purpose	Scoring Instructions
4e	Interview with line staff	To determine the extent to which program rules defined in a way that protect youth and the public.	Audio record and transcribe interview with line staff and youth. Highlight the matches between youth's assigned line worker and the youth's interview on the youth's transcribed interview. Count the frequency and enter in "number" column.

Qualitative Summary of JSO Treatment Concepts

Words and Phrases Defining "Cognitive Distortion Work"

absolve (d) (ing) (s)
accept (ance) (ted) (ting) (s)
accepting responsibility for your actions
accountable (ility)
accurate (cy)
accuse (d) (sing)
acknowledgment
admission
admit (ted) (tance) (ting) (s)
antidependent
apology (ies) (ize) (izes)
approve (al) (ed) (s)
ascribe (d) (ing) (s)
assume (d) (s) responsibility
attribute (d) (ing) (s)
autobiographies
aware (ness)
awareness of self-talk
blame (d) (ing) (less)
catastrophic thinking
catching yourself being stuck
cheerful (ness)
clandestine
closed channel
closed mind
cognizant (ance)
complete (ness)
comply (liance)
conceal (ed) ling) (s)
concede (d) (ing) (s)
concoct (ed) (ing) (s)
condemn (ation) (ed) (s) (ing)
confess (ed) (ing) (ion) (s)
conform (ed) (ing) (s)
conscience
conscious (ness)
contrive (d) (ing) (s)
deceit (ful)
deceive (d) (ing) (s)
deceptive
defend (ed) (ing) (es) (sive)
delude (d) (ing) (s)
delusion (s)
dense
dependency (t) (not on substances)
depression
despondent (cy)
disapprove (s) (al) (ing) (ed)
disclose (ed) (ure)
discourage (d) (ment) (s)
dishonesty
dispassionate (ly)
distort (ed) (ing) (ion) (s)
distrustful
divulge (d) (ing) (s)
downplay (ed) (ing) (s)
elusive (ness)
embellish (ed) (ing) (es)
empathy (for victim, self or others)
endorse (d) (ing) (ment) (s)
evasive (ness)
evasiveness
exaggerate (ed) (ing) (ion) (s)
excuse (d) (ing) (s)
expose (d) (ing) (s)
fabricate (d) (ing) (s)
failure to learn
fallacy (ies)
falsehood (s)
fatalism
feeling what other person feels
feeling what they feel
forgive (ave) (ing) (s)
forgiving yourself
guarded
guilt (less) (y)
helpless (ness)
hide (hid) (den) (ing)
honest (y)

identifiy (ies) (ied) (ification)

impassive (ivity)

impervious (ness)

impotent (cy)

impute (d) (ing) (s)

indifference (t)

inflexible (ility)

integrity

invulnerable (ility)

lack of concern

lies

makes up

melancholy

minimize (d) (ing) (s)

misconceive (d) (ing) (s)

misconception (s)

misinterpret (ation) (ed) (ing) (s)

mislead (d) (ing) (s)

misrepresent (ation) (ing) (s)

misunderstand (stood) (ing) (s)

narcissistic thinking

negative self-image

nonchalance (t)

open (ness)

opened up

overstate (d) (ing) (s)

own (ed) (ing) (s)

ownership

owning up to what you did

pardon (ed) (ing) (s)

permission

perspective

permit (ted) (ting) (s)

point of view

point scoring

powerless (ness)

predicting rejection

project (ed) (tion) (s)

rationalizing

rebel (ling) (lious) (led)

recognize (ed) (ing) (ion) (s)

refuse (d) (ing) to accept

refuse (d) (ing) to acknowledge

remorse (ful)

repress (ed) (ion) (es)

responsibility

responsible for

reveal (ed) (ing) (s)

sanction (ed) (ing) (s)

secret (s) (ive)

self-justification

self -pity

self -report

sensitivity to criticism

sexual assault cycle

sharing

sincere (ity)

stinking thinking

support (ed) (ing) (s)

suppress (ed) (ing) (es)

suspicious

take (took) responsibility

taking charge of your life

tell (old) (ing)

telling everything you've done

thinking errors

thought disorder

time line

truth (s)

uncompromising

unconcern (ed)

understand ownership

understate (d) (ing) (s)

undisclosed

unrevealed

untruth (s)

unyielding

victim empathy

victim injury

victim stance

viewing others as objects

viewpoint

vindicate (d) (s) (ing)

vulnerable

wary

weak

whopper (s)

Words and Phrases Defining "Deviant Arousal Work"

Depro- Provera	deviant "turn-ons"	olfactory
aberrant	deviant vs. normal	physical
arousal control techniques	ejaculate (ion) (ed) (s)	pornography
arouse (d) (ing) (s) (al)	erection	reinforce (d) (s) (ing)
assisted covert conditioning	excite (d) (s) (ing)	reinforcement (s)
awareness of variant cycle	fantasies (sized)	relieve
behavior (al) strategies	filth (y) (iness)	reorient (ation)
behavioral rehearsal	heart rate	repetitive satiate (ion)
boundary (ies)	indulgence (t)	seclusion
bribe(s) (ing) (ed)	isolation	self-indulgence
chemical castration	jack(s) off	sex (ual) modification work
condition (ed) (ing)	lewd	sexual arousal
cool down	masturbate (ation) (d) (ing) (s)	smut (ty)
covert conditioning	masturbatory conditioning	stimulate (d) (ing) (ation
covert sensitization (ize) (ed)	medroxyprogesterone	substance abuse
desensitization (tized)	obscene (ity)	titillate (d) (s) (ing)

Words and Phrases Defining "Relapse Prevention"

SUDs	control (ing) (led) (s)	direction (s)
a continuum that perpetuates cycle	cope with	escape (s)
abstain (inence)	coping (s)	exit (s)
abstinence violation effect	coping strategies	failure to exercise caution
alternative (s)	curb (ed) (ing) (s)	failure to exercise discretion
avoid (ance) (ing) (s)	cycle work	gamble (s)
awareness of cycle	danger (s) (ous)	handle (d) (ing) (s)
backslide (ing) (s)	dare (ing) (s)	hazard (ous) (s)
change	decision (s)	high risk behavior (s)
check (ed) (ing) (s)	detention	ignoring the warning signs
choice (s)	direct (ed) (ing) (s)	immediate gratification

jeopardy (ize)
keeping yourself safe
knowledge of precipitating factors
knowledge of sexually deviant behavior
lapse (d) (ing) (s)
levels of intervention
making good choices
manage (d) (ing) (s)
modeling
monitor (ed) (ing)
offense cycle
option (s)
peril (s) (ous)
precipitating factors
precursors
regress (ed) (ion) (ing)
regulate (s) (ation) (ations)
relapse (s) (d) (ing)
relapse prevention tasks
reoffense
retreat (s)
retrogress (ed) (ing) (ion)
revert (ed) (s) (sion)
risk (ed) (ing) (s) (y)
safety net team
seeming unimportant decision (s)
self-control
self-management
self-defeating
sex (ual) history
standard (s)
trigger (ed) (s)
what family can do
what police can do

Words and Phrases Defining "Increasing Interpersonal Competency"

behavior (nonsexual)
blended and step families
chaotic
clarify (ication) (ied) (s)
codependence
communication style
communication
conflict
cultural norms
culturally conditioned gender identity
education in family therapy
enmeshed
family feuds
family forum
family group work
family problems
family therapy
family issues
family work
fatherhood
friction
how to act or behave
interdependence
interpersonal skills
limits
macho myths
mentoring
modeling
morals
parental training
parenting
peer (issues)
parenting skills
reconstitution
respect
reunification
rigid boundaries
rule(s)
sex education
social generalization
social skill (s)
social skill training
socialization
socially acceptable gender identity
socially appropriate gender identity
support
values training

Words and Phrases Defining "Increasing Personal Competency"

ADHD
Tourette's syndrome
academics
acting without thinking
actualization
agitation
anguish
appropriate behavior
assuage
calm
childish
confusion
displease (sure) (d) (ing) (s)
disruptive behavior
distracted
following instructions
forgetful
healthy day-to-day living
heartache
hedonism
hygiene
hyperactivity
identification
immature
immediate gratification
impulse control
impulsivity
inattention
infantile
integration
interrupts
irritate (d) (ation) (s) (ing)
knowing what's right
locus of control
maintaining a healthy lifestyle
moderation
motor behavior
naive
not thinking it through
personal identification
poor judgment
poor planning skills
poor self-esteem
projection
recreation
resent (ed) (ing) (s) (ment)
sadness
self-awareness
self -evaluation
self-efficacy
self-esteem
skills development services
skills training
soothe (d) (ing) (s)
synthesizing
tics
unfinished business
values
vocational training

Words and Phrases Defining "Healing Personal Victimization"

abandon(ed) (ment)
batter (ed)
beat (en)
bruised
coming to terms
dealing with what happened to you
death (died)
desert (ed) (ion)
doing your own victim work
domestic violence
emotional abuse
family violence

gang
grief
hurt
left alone
loss
mourning
neglect
past trauma
physical abuse
resiliency
strike (struck) (s)
sorrow
trauma (tized) (tization) (s)
taking care of what happened to you
understanding how and why
victim to victimizer
whipped
yelled at (from others)

Words and Phrases Defining "Decreasing Exploitative Behaviors"

abuse (d) (ing) (s)
admire (ation) (d) (ing) (s)
affection
aggress (ive) (ion) (es) (ed)
anger
annoy (ed) (ing) (ance) (s)
antagonistic (ism)
argue (d) (ing) (s)
argumentative
assault (ed) (ing) (ive) (s)
awareness of intimacy
belligerent (ce)
bias
bigotry
browbeat (s)
bullying
combat (ive) (s)
contend (s) (ing) (ed) (ious)
contention
discrimination
domineer (ed) (ing) (s)
enrage (d) (s)
exasperate (d) (ing) (ion) (s)
exploit (ative) (ion) (s) (ing)
fond (ness)
frighten (s)
frustrate (d) (ing) (tion) (s)
fury (ious)
gets physical
getting your needs met without hurting others
groom (ed) (ing)
grooming victims
harass (ed) (es) (ing)
harassment
harmony
healthy sexual expression
healthy sexuality
hit (s) (ing)
hostile (ility)
incense (d) (s)
indecent (cy)
indignant (nation)
infurate (s) (d)
intimacy
intolerance (t)
label (led) (ling)
Learning to have healthy relationships with opposite sex
love (d) (ing) (s)
malice (ious) (iousness)
manipulating
noncoercive sexuality
nonexploitative (ion)
outrage (d)
partnership
persecute (d) (ing) (s)
placate (ed) (s) (ing)
positive relationships
positive sexuality
positive sexual expression
power

predatory

prejudice

prey (ed) (ing) (s)

racism

rage (d) (ing) (s)

scare (ing)

sensitivity

sequester (ed) (s)

sexism

slap (s) (ing) (ped)

sportsmanship

stalk (s) (ing) (ed)

strife

tease (d) (ing) (s)

temper

tender (ness)

terror (ize) (izes)

threat (en) (ened) (s) (ening)

tolerance

torment (ed) (ing) (s) (or)

trick (ed) (ing) (s) (ery)

turmoil

tyrannize (d) (ing) (s)

wrath

yell (s) (ing) (at or towards others)

Appendix B

DCFS Juvenile Sex Offender Residential Program

Quality Assurance Inventory

(Revised June 9, 1996)

INVENTORY 1: TARGET POPULATION

PROGRAM:_____ EVALUATOR (S): _____

_____

Date: __/__/__ _____

DOCUMENTATION

Targeted Population Served	**Risk**	Low	Medium	High	Excellent
Youth are typically more predatory, violent, entrenched in sexual offending pattern. Youth with patterned repetitious sexual offenses and acting out behaviors, and/or who have used force or weapons in committing their offenses, i.e. more serious or higher degree of severity of sexual offending and/or who have a propensity to act out with same-age peers besides their victims. An Intensive sex offender specific structured program is necessary.		___	___	___	___
Youth have had a prior history of sex offending treatment and present a significant risk to the community. Youth have extensive behavioral and emotional problems and are sexually offending. Youth who have a very high need for intensive sex offender specific clinical intervention and who cannot receive adequate supervision and treatment in group or foster sex offender specific enriched homes.	**Need**	Low	Medium	High	Excellent
		___	___	___	___

Sex Offender Specific Assessment Prior to Placement:	**Need**	Low	Medium	High	Excellent
Youth have had a Level A assessment.		___	___	___	___
Youth have had a Level B, aex offender specific assessment and/or a Level C, comprehensive sex offender specific evaluation.		___	___	___	___
Sex Offender Specific Staffing Conducted Prior to Placement					
Youths' cases have been staffed by professionals with juvenile sex offender specific training and qualifications per professional discipline.		___	___	___	___

INVENTORY 2: PROGRAM INTAKE CRITERIA AND PROCESS

Preadmission Criteria	Needs Improve-ment	Satisfactory	Quality	Superior
Referent has obtained or performed a NOJOS Level B Sex Offender Specific Assessment or Level C, comprehensive offender specific evaluation.	___	___	___	___
Program has written intake criteria including gender of youth, range of age, DSM IV diagnostic categories that the program will not work, profiles of youth, level of risk to community and other clients, cognitive capabilities of youth, level of parental and/or community support required, judicial and legal requirements, other criminal or antsocial behaviors that do not preclude admission such as fire setting, assault, and so forth	___	___	___	___
Program Intake Process				
Program has clear and written intake procedure.	___	___	___	___
Written intake procedure is distributed to DCFS regions.	___	___	___	___
Program has designated intake coordinator.	___	___	___	___
Program has communicated to DCFS regions who intake coordinator is.	___	___	___	___
Program determines appropriateness for placement within 14 days of receipt of referral.	___	___	___	___
Program conducts sex offender specific intake assessment, that includes JSO specific assessment form and interview.	___	___	___	___

INVENTORY 3: JUVENILE SEXUAL OFFENDING TREATMENT SERVICE CONSTELLATION

Contractor provides written documentation to contract monitor and caseworker specifying reasons for determination and recommendations for alternative placements for unacceptable youth.	___	___	___	___
Program has obtained releases of information.	___	___	___	___
Program provides youth and parents/guardians written copies of program procedures and goals.	___	___	___	___
Treatment should include intensive strategies for youth's sexual assault cycle work to assist in relapse prevention. Program shall meet minimum standards of treatment of juvenile sex offenders as specified by the National Task force on Juveniles Offending Sexually (1993) and Network on Juveniles Offending Sexually.	___	___	___	___
Treatment plans for each youth shall show evidence of offense-specific treatment groups and psycho social groups that include daily living skills, sex education, and family and individual therapy.				
Implementation of treatment strategies to work on youth's assault cycle, behavioral strategies to reduce deviant sexual arousal, and strategies based on the youth's assault cycle to assist in relapse prevention.	___	___	___	___
Juvenile Sex Offenses Specific Treatment Goals (*Include increases in the offender's adaptive levels of functioning behaviorally, emotionally, socially, cognitively, and physiologically*):				
Increased accountability for sexually offending behavior	___	___	___	___
Disclosure of offending behavior history	___	___	___	___
Decreased deviant arousal, behavior, and thinking	___	___	___	___
Recognition of denial	___	___	___	___
Deviant arousal addressed	___	___	___	___

	Needs Improve-ment	Satisfactory	Quality	Superior
Sex education psycho educational group to teach juvenile sex offenders about human sexuality and enhance their understanding of healthy, appropriate adolescent sexual expression. Clinicians should use a sex education curriculum that specifically addresses the unique characteristic of adolescent sex offenders. Sex education issues and information about AIDS and STD's should be integrated with program design.	___	___	___	___
Clinical treatment plans and notes document sex education.	___	___	___	___
Individual Therapy and Family Therapy				
Frequency: Minimum twice per week	___	___	___	___
Individual therapy supplements group treatment.	___	___	___	___
Clinical treatment plans and notes document therapy.	___	___	___	___
Multifamily group therapy and individual family therapy sessions are integrated in treatment plans and JSO specific. If family is unavailable or refuses to participate, the contractor will document efforts to engage them in treatment plan.	___	___	___	___
Clinical treatment plans and notes document therapy.	___	___	___	___
Other Therapy Modalities	___	___	___	___
Program arranges for other therapies as needed such as diagnostic information, psychopharmacological management, substance abuse counseling, psychiatric services, and so forth	___	___	___	___
Program documents management of medications.	___	___	___	___

Reporting Information and Progress to DCFS	Needs Improve-ment	Satisfactory	Quality	Superior
Quarterly update reports are submitted to DCFS and documented in file.	___	___	___	___
Client staffings are held weekly. At least two per month should include DCFS and other appropriate agency staff. Program records reflect that DCFS staff or other staff were invited to two staffings per month.	___	___	___	___
Life Skills Training/Day Treatment (SDS)				
Frequency: Three hr/day	___	___	___	___
Group and individual work center on mastery of life and social skills. This training and treatment encompass both social skills peculiar to this population and traditional independent living skills.	___	___	___	___
Documentation of skills development services in file.	___	___	___	___
Skills development treatment plan, program, and service have clinical review quarterly by licensed practitioner on staff.	___	___	___	___
Documentation includes daily entry with the date, number of hours of service, and a brief description of the service.	___	___	___	___
Education				
Youth are in a program accredited by the local school district.	___	___	___	___
Recreation				
Frequency: Minimum twice per week	___	___	___	___
Organized, structured recreational activities with increased staff to youth ratio commensurate with the location of the activity.	___	___	___	___
Recreation activities are documented.	___	___	___	___

INVENTORY 4: SUPERVISION

Program's Intensity of Supervision	Low	Medium	High	Excellent
Program provides 24 hr/day awake supervision	___	___	___	___
Program has 1:3 staff to client ratio day hours	___	___	___	___
Program has 1:5 staff to client ratio after hours	___	___	___	___
Contractor maintains staff logs or time sheets to document 24 hr awake supervision.	___	___	___	___
Facility Compositions				
Location within community	___	___	___	___
Physical layout	___	___	___	___
Physical monitoring system	___	___	___	___
Self-containment of schooling and other services that limit further offending behaviors	___	___	___	___
Program's Structure (System), Rules, and Practices				
Program has comprehensive program master manual.	___	___	___	___
Program has documented behavior management system.	___	___	___	___
Program has levels with entrance and exit behaviors.	___	___	___	___
Program documents youth's progress or lack of progress.	___	___	___	___
Program has self-evaluation of their behavior management system's effectiveness.	___	___	___	___
Program has clear written program rules and practices, that include resident's behavior including bedroom, bathroom, and interpersonal behaviors and boundaries.	___	___	___	___
Program has written procedure regarding room assignment and boundaries for all youth.	___	___	___	___
Program has written policy and standards for client behaviors towards each other.	___	___	___	___
Program has written policy and standards for client behaviors towards each other.	___	___	___	___

	Needs Improvement	Satisfactory	Quality	Superior
Written program management system, process, and rules are given to youths.	___	___	___	___
Youths can articulate program system, process, and rules.	___	___	___	___
Staff can articulate program system, process, and rules.	___	___	___	___
Program has written policy stating the program violation process, the type of discipline to be imposed, and the consequences to be implemented when a youth fails to comply with treatment demands.	___	___	___	___
Youths have received and understand policy.	___	___	___	___
Program violation written policy includes a process which violations are determined to be true.	___	___	___	___
Program violation written policy includes process which violations are reported and to who report to caseworker, referral to police, report to court, and other staff.	___	___	___	___
Program violation written policy includes consequences as restrictions of movement on grounds, restriction from home visits, loss of privileges, movement along behavior management level system, temporary suspension from group, restraints, time outs, termination from program.	___	___	___	___
Youths can generally articulate violation process.	___	___	___	___
Program staff communicates all infractions of rules to each other.	___	___	___	___
Program documents its attempts to carry out its consequences.	___	___	___	___
Program has written grievance procedure for youths and parents.	___	___	___	___

	Needs Improve-ment	Satisfactory	Quality	Superior
If youth is to be terminated from program, therapists make recommendations for alternative programming.	___	___	___	___
Home Visits				
Program has clear written supervision requirements of parents/custodians.	___	___	___	___
Parents/custodians understand and are trained on supervision requirements.	___	___	___	___
Program documents parent's/custodian's home supervision training.	___	___	___	___
Program conducts process to insure parent's supervision.	___	___	___	___

INVENTORY 5: AFTERCARE

	Needs Improve-ment	Satisfactory	Quality	Superior
Program has an after care plan for the youth that includes individual, family, and group counseling as jointly defined and agreed to by DCFS staff and program treatment staff.	___	___	___	___
Contractor can provide or arrange therapeutic intervention with youth under DCFS custody but living at home or other community programs.	___	___	___	___
Contractor has step down programming component.	___	___	___	___
Contractor maintains a copy of the youth's aftercare plan.	___	___	___	___
Aftercare plan is attached with the youth's discharge summary from the facility.	___	___	___	___
Services are documented in client's individual file.	___	___	___	___

INVENTORY 6: STAFF QUALIFICATIONS AND TRAINING

	DOCUMENTATION		
Qualified Sex Offender Therapists	No	Not Yearly	Yes
BCI is performed yearly.	___	___	___
USSDS is performed yearly.	___	___	___

Qualified Sex Offender Therapists	Needs Improve-ment	Satisfactory	Quality	Superior
Therapy services must be provided by qualified staff as licensed by the Department of Professional Licensing. Documentation is in personnel file.	___	___	___	___
Therapy services must be provided by a juvenile sex offender therapist or trainee who is directly supervised by a sex offender specific therapist.	___	___	___	___
Program has available a copy of the therapist's license and documentation of his or her supervised clinical experience working with juvenile sexual offenders. Documentation is in personnel file.	___	___	___	___
Therapists have signed a code of conduct.	___	___	___	___
Sex Offender Specific Trained Residential Staff				
Residential staff shall complete an additional 30 hr of training within first 12 months and then 30 hr per year.	___	___	___	___

	Needs Improve-ment	Satisfactory	Quality	Superior
Training includes an orientation to the provider's contract with the division, applicable federal entitlement requirements, DHS contractor code of conduct, adolescent behavior and development, behavior management and discipline methods, court procedures, first aid, medical and emergency procedures, and parenting skills.	___	___	___	___
Training include goals of juvenile sexual offending treatment, program modalities of treatment, supervision of juveniles offending sexually, program's policy and procedures.	___	___	___	___
Program maintains documentation of training received by staff, including dates of training, hr of training, subject, and name of the trainer or other resource used to provide the training.	___	___	___	___
Residential staff are certified SDS providers. Documentation is in personnel file.	___	___	___	___
Staff sign program code of conduct.	___	___	___	___

INVENTORY 7: COMMUNITY-BASED SEX OFFENDER SPECIFIC PROGRAM AND PROGRAMMING

	No	Yes
Provider is licensed by DHS Office of Licensing as a residential facility.	___	___
Program has a copy of NOJOS Standards and Protocols and utilizes NOJOS Standards and Protocols (1994).	___	___
Program understands how it operates within NOJOS treatment/placement level system.	___	___

Contractor Provides Maximum Nonsecure Supervision and Intensive Clinical Intervention	Needs Improve-ment	Satisfactory	Quality	Superior
Program provides services for juveniles who present severe risk to reoffend within the community (summary of Inventory 1 Target Population).	___	___	___	___
Program provides most intensive and expert juvenile sex offender clinical intervention services within the community (summary of Inventory 3 JSO Treatment Services Constellation).	___	___	___	___
Program provides most intensive juvenile sex offender supervision within the community and within the program itself (summary of Inventory 4 Supervision).	___	___	___	___
Program has policy and procedure manual.	___	___	___	___
Program has master therapy manual.	___	___	___	___
Program has program structure/system manual.	___	___	___	___
Program has personnel manual.	___	___	___	___
Program has youth manual/handbook.	___	___	___	___
Program has parent manual/handbook.	___	___	___	___
Program has submitted copies of above to DCFS regions.	___	___	___	___

Program Has a Step-Down System for Graduated Intensities of Service, Continuum of Care, and Cost Effective Delivery of Services	Needs Improvement	Satisfactory	Quality	Superior
Program identifies and places overplaced youths in appropriate step-down resource.	___	___	___	___
Program has Level Four available within its agency of allied agencies.	___	___	___	___
Program has Level Three programming available within its agency or allied agencies.	___	___	___	___
Program has Level Two available within its agency or allied agencies.	___	___	___	___
Length of Stay in Program				
Program documents average length and range of stay.	___	___	___	___
Program communicates average length and range of stay to youth, parents, and DCFS staff.	___	___	___	___
Program Evaluates Reoffending Behaviors of Clients				
Program tracks sex offense rearrest records of former residents.	___	___	___	___
Program tracks former clients reoffending behaviors.	___	___	___	___

Appendix C

Figures

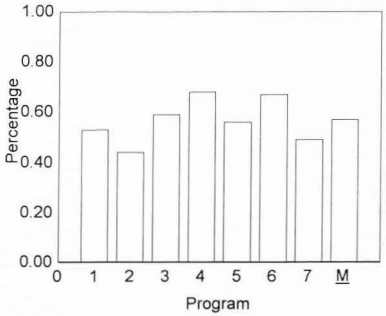

Figure C.1. A comparison of weighted risk with the mean (M) and across the programs.

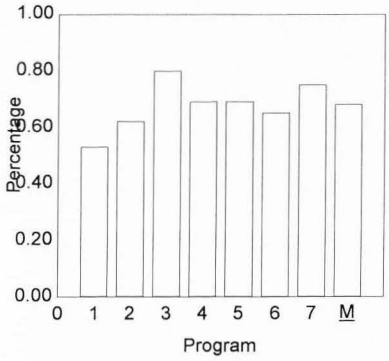

Figure C.2. A comparison of weighted need with the mean (M) and across the programs.

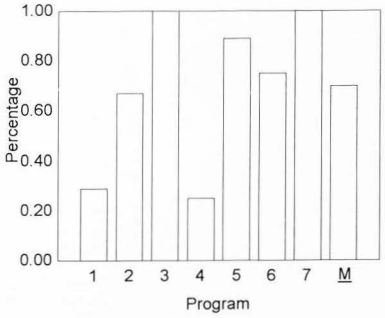

Figure C.3. Percentage of offenders presenting with sexual disorders compared by program and mean (M).

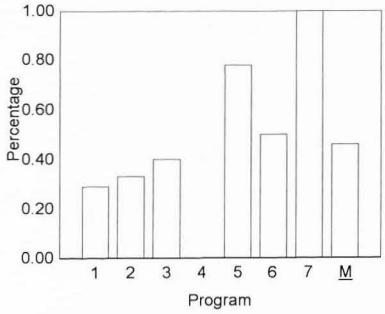

Figure C.4. Percentage of offenders presenting with features of personality disorders compared by program and mean (M).

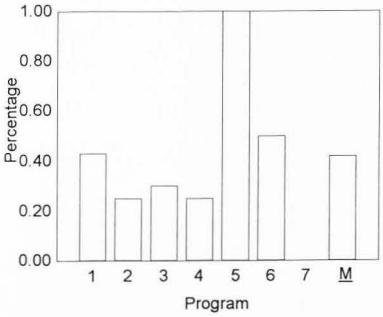

Figure C.5. Percentage of offenders presenting with conduct disorders compared by program and mean (M).

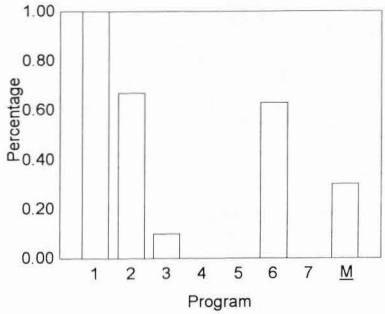

Figure C.6. Percentage of offenders presenting with impulse disorders compared by program and mean (M).

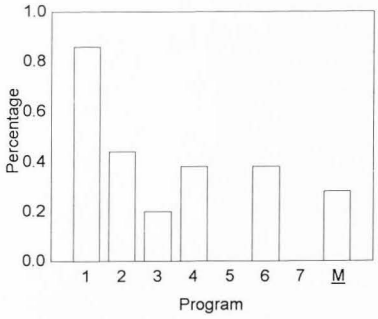

Figure C.7. Percentage of clients presenting with mood disorders compared by program and mean (M).

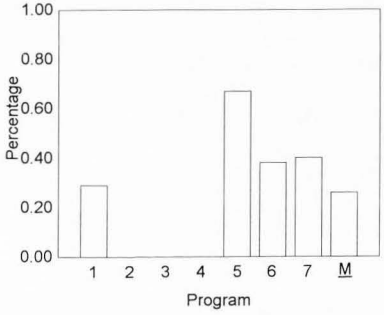

Figure C.8. Percentage of offenders victimized by mother/stepmother compared by program and mean (M).

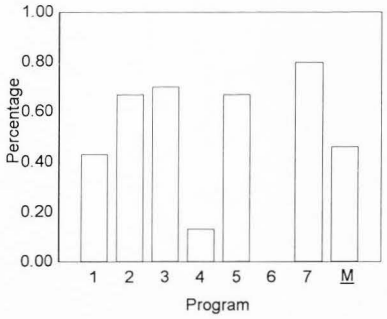

Figure C.9. Percentage of offenders victimizing peers compared by program and mean (M).

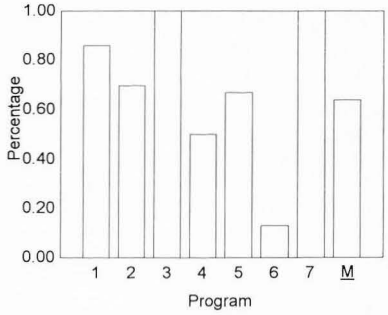

Figure C.10. Percentage of offenders victimizing a combination of family, acquaintances, and strangers compared by program and mean (M).

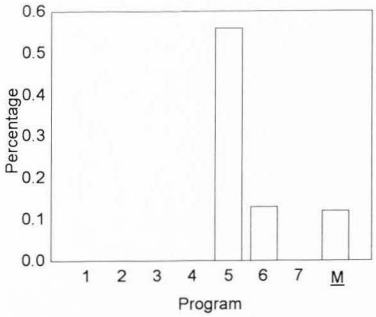

Figure C.11. Percentage of offenders with three or more juvenile sex offender specific placements compared by program and mean (M).

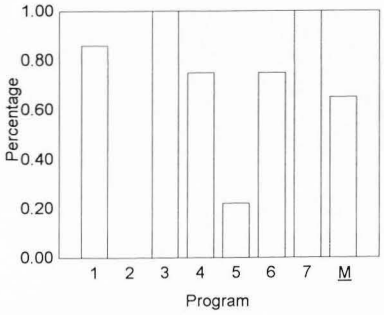

Figure C.12. Percentage of client files with treatment goal of reducing deviant arousal compared by program and mean (M).

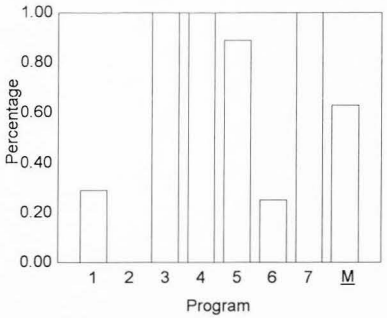

Figure C.13. Percentage of client files with treatment goal of relapse prevention compared by program and mean (M).

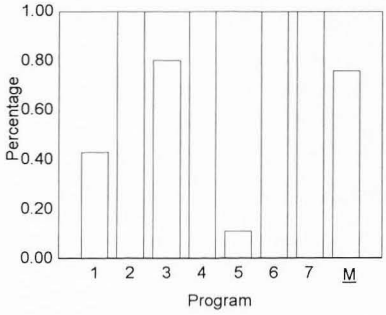

Figure C.14. Percentage of client files with treatment goal of increasing personal competency compared by program and mean (M).

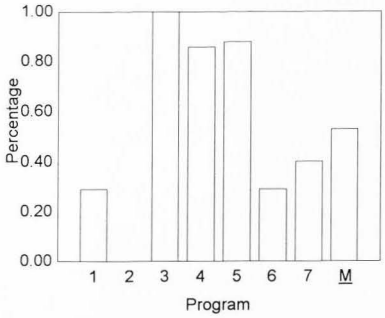

Figure C.15. Percentage of client files with treatment goal of decreasing exploitative behaviors compared by program and mean (M).

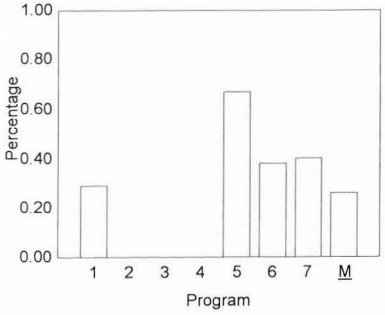

Figure C.16. Percentage of charts indicating that quarterly summary had been sent compared by program and mean (M).

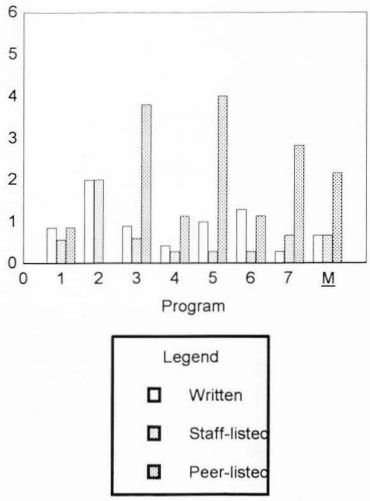

Figure C.17. Comparison of frequency of match between youths' listing of bedroom rules and written rules, rules reported by line staff, and rules reported by other youth.

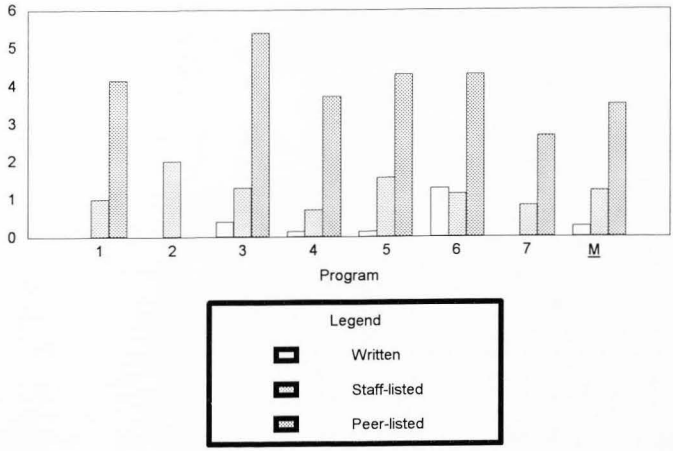

Figure C.18. Comparison of frequency of match between youths' listing of bathroom rules and written rules, rules reported by line staff, and rules reported by other youth.

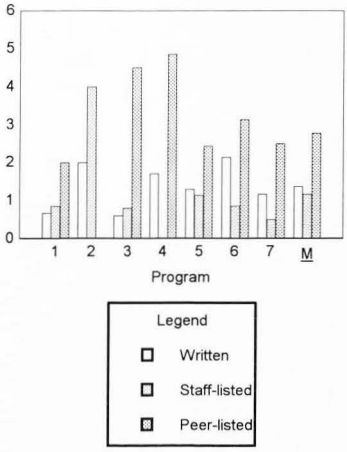

Figure C.19. Comparison of frequency of match between youths' listing of interpersonal rules and written rules, rules reported by line staff, and rules reported by other youth.

Appendix D

Tables

Table D.1

Assessment

Item	Program 1 n=7	2 n=3	3 n=10	4 n=8	5 n=9	6 n=8	7 n=5	M N=50	F
Do client files contain a Level A assessment?	0%	0%	10%	0%	0%	0%	0%	1%	.64
Standard score	-.03	-.03	2.25	-.03	-.03	-.03	-.03	0.00	
Do client files contain a Level B or a Level C assessment?	86%	100%	90%	100%	100%	100%	100%	97%	.66
Standard score	-.23	0.00	-1.67	0.00	0.00	0.00	0.00	0.00	

Table D.2

Number of Other Juvenile Sex Offender Specific Placements by Specified Program and Mean (M)

Item	Program 1 n=7	2 n=3	3 n=10	4 n=8	5 n=9	6 n=8	7 n=5	M N=50	F
One	29%	50%	0%	38%	11%	0%	40%	26%	1.57
Two	0%	0%	0%	0%	11%	0%	20%	4%	.98
Three or More	0%	0%	0%	0%	56%	13%	0%	12%	5.05***
F									5.42**
Total with One or More	29%	50%	0%	38%	78%	13%	60%	42%	2.09
Standard Score	-.52	.32	-1.68	-.16	1.44	-1.16	.72	0.00	

** Significant at $p \leq .01$

***Significant at $p \leq .001$

Table D.3

Average Placement/Treatment Experiences

	Program								
	1	2	3	4	5	6	7	M	
Item	n=7	n=3	n=10	n=8	n=9	n=8	n=5	N=47	F
On the average, how many other JSO specific residential placements has the youth had?	.30	2.00	.60	.40	1.30	0.00	.50	.50	2.00
Standard score	-.57		.24	-.30	2.14	-1.38	-.03	0.00	
On the average, how many JSO specific outpatient episodes has the youth had?	.30	1.00	.60	.30	.70	.60	.50	.50	.47
Standard score	-1.43		.71	-1.43	1.43	.71	0.00	0.00	
On the average, how long has juvenile been in current placement (in months)?	20.00		16.00	12.00	10.00	19.00	9.00	14.00	1.98
Standard score	1.33		.39	-.55	-1.01	1.09	-1.25	0.00	

Table D.4

Percentage of Youth Signing Their Treatment Plan Compared by Program and Mean (M)

	Program							
	1	2	3	4	5	6	7	M
Item	n=7	n=3	n=10	n=8	n=9	n=8	n=5	N=50
Have youth signed a mental health treatment plan?	86%	33%	100%	0%	100%	0%	0%	45%
Have youth signed a skills development treatment plan?	86%	33%	100%	0%	100%	0%	0%	45%

Table D.5

Average Number of Treatment Words (Content), Treatment Goals (Depth), and Treatment Categories (Breadth) Reported by the Youth in Each Program Compared with Mean (M)

	Program								
Item	1 n=7	2 n=1	3 n=10	4 n=8	5 n=7	6 n=8	7 n=6	M N=47	SD
On the average, to what extent do youth understand the content of youth's treatment plan ?	9.00	13.00	9.00	6.00	6.00	9.00	8.00	8.57	1.63
Standard score	.26	2.72	.26	-1.58	-1.58	.26	-.35	0.00	
On the average, to what extent do youth understand the depth of youth's treatment plan?	5.00	4.00	4.00	3.00	3.00	3.00	3.00	3.57	.79
Standard score	1.81	.54	.54	-.72	-.72	-.72	-.72	0.00	
On the average, to what extent do youth understand the breadth of youth's treatment plan?	4.00	4.00	3.00	3.00	2.00	2.00	3.00	3.00	.82
Standard score	1.22	1.22	0.00	0.00	-1.22	-1.22	0.00	0.00	

Table D.6

Average Number of Treatment Words (Content), Treatment Goals (Depth), and Treatment Categories (Breadth) Reported by the Line Workers in Each Program Compared with Mean (M)

	Program								
	1	2	3	4	5	6	7	M	
Item	n=2	n=2	n=2	n=2	n=2	n=1	n=2	N=13	SD
On the average, to what extent do line staff understand the content of youth's treatment plan?	1.00	1.00	8.00	8.00	8.00	1.00	7.00	4.86	3.63
Standard score	-1.06	-1.06	.87	.87	.87	-1.06	.59	0.00	
On the average, to what extent do line staff understand the depth of the youth's treatment plan?	0.00	2.00	4.00	4.00	3.00	1.00	4.00	2.57	1.62
Standard score	-1.59	-.35	.88	.88	.27	-.97	.88	0.00	
On the average, to what extent do line staff understand the breadth of the youth's treatment plan?	2.00	2.00	4.00	3.00	2.00	1.00	4.00	2.57	1.13
Standard score	-.50	-.50	1.27	.38	-.50	-1.39	1.27	0.00	

Table D.7

Percentage of Implementation of Medicaid Treatment Planning Procedures in Client Files Compared by Program and Mean (M)

	Program								
	1	2	3	4	5	6	7	M	
Item	n=7	n=3	n=10	n=8	n=9	n=8	n=5	N=50	F
Does mental health treatment plan contain the signature of a licensed practitioner?	86%	67%	100%	100%	100%	100%	100%	.93	1.86
Standard score	-.58	-2.17	.58	58	.58	.58	.58	0.00	
Does mental health treatment plan contain the credentials of individuals who will furnish the services?	86%	67%	100%	100%	100%	100%	100%	.93	1.86
Standard score	-.58	-2.17	.58	58	.58	.58	.58	0.00	
Does mental health treatment plan contain a statement of disability?	100%	100%	100%	100%	100%	100%	100%	100%	
Standard score	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
Does mental health treatment plan specify how long treatment is expected to continue?	100%	100%	100%	100%	100%	100%	100%	100%	
Standard score	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	

(table continues).

Item	Program 1 n=7	2 n=3	3 n=10	4 n=8	5 n=9	6 n=8	7 n=5	M N=50	F
Do mental health treatment plan goals specify measures to evaluate whether objectives are met?	100%	100%	100%	100%	100%	100%	100%	100%	
Standard score	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
Is skill development treatment plan signed by a licensed. practitioner, licensed certified social worker, social service worker, RN, LPN, or other person certified to provide Skills development services?	100%	67%	90%	100%	100%	100%	100%	100%	3.18*
Standard score	.55	-2.46	-.36	.55	.55	.55	.55	08	
Does skills development plan contain the credentials of the individuals who will furnish the services?	100%	67%	90%	100%	100%	100%	100%	100%	3.18*
Standard score	.55	-2.46	-.36	.55	.55	.55	.55	08	
Does skills development plan specify how long treatment is expected to continue?	100%	100%	100%	100%	100%	100%	100%	100%	
Standard score	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	

(table continues)

	Program								
	1	2	3	4	5	6	7	M	
Item	n=7	n=3	n=10	n=8	n=9	n=8	n=5	N=50	F
Do skills development treatment goals specify measures to evaluate whether objectives are met?	100%	100%	100%	100%	100%	100%	100%	100%	
Standard score	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
F								1.33	
Implementation index	.97	.85	.98	1.00	1.00	1.00	1.00	.97	5.23***

Table D.8

Percentage of Client Files Containing Documentation That Quarterly Summary was Sent Compared by Program and Mean (M)

	Program								
	1	2	3	4	5	6	7	M	
Item	n=2	n=2	n=2	n=2	n=2	n=1	n=2	N=13	F
Was quarterly summary of treatment plan sent to DCFS/DYC?	71%	0%	100%	33%	100%	25%	100%	.61	9.70***
Standard score	.26	-1.56	1.00	-.72	1.00	-.92	1.00	0.00	

Table D.9

Average Number of Matches Between Line Staffs' Listing and Written Rules About Bedroom, Bathroom, and Interpersonal Behavior

	Program								
	1	2	3	4	5	6	7	M	
Item	n=2	n=2	n=2	n=2	n=2	n=1	n=2	N=13	SD
Bedroom behavior	1.00	1.00	2.00	0.00	1.00	1.00	1.00	1.00	.53
Standard score	0.00	0.00	1.89	-1.89	0.00	0.00	0.00	0.00	
Bathroom behavior	0.00	0.00	1.00	0.00	0.00	0.00	0.00	.14	.35
Standard score	-.40	-.40	2.46	-.40	-.40	-.40	-.40	0.00	
Interpersonal behavior	1.50	1.50	2.00	1.00	1.50	1.00	1.50	1.43	.32
Standard score	.22	.22	1.78	-1.34	.22	-1.34	.22	0.00	

Appendix E

Multiple Comparisons

Table E.1

Number of Offenders with Specified Risk Characteristics

Characteristic	Used weapon	Inflicted discernible harm	Used force	Escalated frequency, duration, or type of aggression	Multiple victims	Repeated sexual assault cycle	Peer victim
Inflicted discernible harm	*						
Used force	***	***					
Escalated frequency, duration, or type of aggression	***	***					
Multiple victims	***	***					
Repeated sexual assault cycle	***	***					
Peer victim	***		***	***	***	***	***
Groomed victim	***	***	*	*			***

* $p \leq .05$

** $p \leq .01$

*** $p \leq .001$

Table E.2

Percentage of Offenders in Specified Program

Who Used Force to Coerce Their Victim

Program	1	2	3	4	5	6
2						
3	**					
4	*					
5	**					
6	***					
7			**	**	***	***

* $p \leq .05$

** $p \leq .01$

*** $p \leq .001$

Table E.3

Percentage of Offenders in Specified Program

Having at Least One Nonconsensual Peer Victim

Program	1	2	3	4	5	6
2						
3						
4			**			
5				*		
6		*	***		**	
7				**		**

* $p \leq .05$

** $p \leq .01$

*** $p \leq .001$

Table E.4

Number of Offenders with Specified Need Characteristics

Need	Documented behavioral and emotional problems	Victim is in home
Victim is in home		
History of JSO treatment and continues to offend	***	**

** $p \leq .01$

*** $p \leq .001$

Table E.5

Percentage of Offenders Given Specified Psychiatric Diagnosis

Disorder	Sexual	Features of personality	Conduct	ADHD	Impulse	Mood	Anxiety	Learning	Schizophrenia/ Psychosis	Substance abuse	Elimination disorders	Mental retardation	Adjustment
Features of personality	***							***					
Conduct	***						**						
ADHD	***		***						*	***	***		***
Impulse	***	*	***								***		
Mood	***	*	***		***						***	**	
Anxiety	***	***	***	***									
Learning	***	***	***										
Schizophrenia/ psychosis	***	***	***										

(table continues)

Disorder	Sexual	Features of personality	Conduct	ADHD	Impulse	Mood	Anxiety	Learning	Schizophrenia/ Psychosis	Substance abuse	Elimination disorders	Mental retardation	Adjustment
Substance abuse	***	***	***	***	**	**							
Elimination	***	***	***	***	***	***	*						
Mental retardation	***	***	***	***	**	***	*						
Adjustment	***	***	***	***	***	***	**				*	*	

* $p \leq .05$

** $p \leq .01$

*** $p \leq .001$

Table E.6

Percentage of Offenders in Specified Program Diagnosed with Sexual Disorders

Program	1	2	3	4	5	6
2						
3	***					
4			***			
5	**			***		
6	*			**		
7	**			***		

* $p \leq .05$

** $p \leq .01$

*** $p \leq .001$

Table E.7

Percentage of Offenders in Specified Program Diagnosed with Features of Personality Disorders

Program	1	2	3	4	5	6
2						
3						
4						
5	*			***		
6				*		
7	**		*	***		*

* $p \leq .05$

** $p \leq .01$

*** $p \leq .001$

Table E.8

Percentage of Offenders in Specified Program

Diagnosed with Conduct Disorders

Program	1	2	3	4	5	6
2						
3						
4						
5	**	***	***	***		
6					*	
7					***	*

* $p \leq .05$

** $p \leq .01$

*** $p \leq .001$

Table E.9

Percentage of Offenders in Specified Program

Diagnosed with Impulse Disorders

Program	1	2	3	4	5	6
2						
3	***	**				
4	***	***				
5	***	***				
6	*		***	***	***	
7	***	**				***

* $p \leq .05$

** $p \leq .01$

*** $p \leq .001$

Table E.10

Percentage of Offenders in Specified Program

Diagnosed with Mood Disorders

Program	1	2	3	4	5	6
2	**					
3	***					
4	*					
5	***			*		
6	*				*	
7	***					

* $p \leq .05$

** $p \leq .01$

*** $p \leq .001$

Table E.11

Percentage of Offenders Receiving

Specified Type of Abuse

Program	Sexual	Physical
Physical		
Neglect	***	***

*** $p \leq .001$

Table E.12

Percentage of Offenders Victimized by Specified Relation

	Father	Acquaintance	Mother	Sibling
Acquaintance	*			
Mother	***	*		
Sibling	***	**		
Stranger	***	***	*	

* $p \leq .05$

** $p \leq .01$

*** $p \leq .001$

Table E.13

Percentage of Offenders

Victimized by Mother/Stepmother

Program	1	2	3	4	5	6
2						
3						
4						
5	*	*	***	***		
6			*			
7						

* $p \leq .05$

** $p \leq .01$

*** $p \leq .001$

Table E.14

Percentage of Offenders

Offending Against Specified Gender

Gender	Female+Male	Female only
Female only	***	
Male only	***	**

** $p \leq .01$

*** $p \leq .001$

Table E.15

Percentage of Offenders in Specified Program

Offending Against Peer Victims

Program	1	2	3	4	5	6
2						
3						
4						
5						
6		*	**		**	
7						**

* $p \leq .05$

** $p \leq .01$

*** $p \leq .001$

Table E.16

Number of Offenders Offending Against Type of Relationship

Relationship	Combination	Family	Acquaintance
Family	***		
Acquaintance	***	**	
Stranger	***	***	

** $p \leq .01$

*** $p \leq .001$

Table E.17

Number of Offenders with One, Two, or Three or More Other Placements

Times	1	2
2	***	
3+	*	

* $p \leq .05$

*** $p \leq .001$

Table E.18

Percentage of Offenders in Specified Program Having Had Three or More Residential Settings

Program	1	2	3	4	5	6
2						
3						
4						
5	***	**	***	***		
6					**	
7						

** $p \leq .01$

*** $p \leq .001$

Table E.19

Number of Offenders with Specified Treatment Goal

Goal	Remediating cognitive distortions	Reducing deviant arousal	Relapse prevention	Healing personal victimization	Interpersonal competency	Personal competency
Reducing deviant arousal	**					
Relapse prevention	**					
Healing personal victimization	***	***	***			
Interpersonal competency		**	**	***		
Personal competency				***	**	
Decreasing exploitative behaviors	***			***	***	

** $p \leq .01$

*** $p \leq .001$

Table E.20

Percentage of Offenders in Specified

Program with Treatment Goal of Reducing Deviant Arousal

Program	1	2	3	4	5	6
2	***					
3		***				
4		**				
5			***	**		
6		**			**	
7		***			***	

** $p \leq .01$

*** $p \leq .001$

Table E.21

Percentage of Offenders in Specified

Program with Treatment Goal of Relapse Prevention

Program	1	2	3	4	5	6
2						
3	***	***				
4	**	***				
5	***	***				
6			***	***	***	
7	***	***				***

** $p \leq .01$

*** $p \leq .001$

Table E.22

Percentage of Offenders in Specified

Program with Treatment Goal of

Increasing Personal Competency

Program	1	2	3	4	5	6
2	*					
3	*					
4	***					
5	*	***	***	***		
6	***				***	
7	**				***	

* $p \leq .05$

** $p \leq .01$

*** $p \leq .001$

Table E.23

Percentage of Offenders in Specified

Program with Treatment Goal of Decreasing Exploitative Behaviors

Program	1	2	3	4	5	6
2						
3	***	***				
4	**	**				
5	**	**				
6			***	**	**	
7				*	*	

* $p \leq .05$

** $p \leq .01$

*** $p \leq .001$

Table E.24

Percentage of Offenders in Specified Program with Skills Development Plans Signed by Clinician

Program	1	2	3	4	5	6
2	**					
3		**				
4		***				
5		***				
6		***				
7		***				

** $p \leq .01$

*** $p \leq .001$

Table E.25

Percentage of Offenders in Specified Program with Credentialed Skills Development Plan

Program	1	2	3	4	5	6
2	**					
3		**				
4		***				
5		***				
6		***				
7		***				

** $p \leq .01$

*** $p \leq .001$

Table E.26.

Percentage of Charts Noting

Quarterly Summary Had Been Sent

Program	1	2	3	4	5	6
2	***					
3		***				
4	**		***			
5		***		***		
6	**		***	***	***	
7		***				***

Appendix F

Pilot Study

Target Population

1. Does the program serve juveniles who present severe risk to reoffend within the community?

The program's weighted risk was .41, suggesting moderate risk.

2. What risk characteristics describe the population?

Table F.1 depicts the risk characteristics. Groomed victim and repeated sexual assault cycle occurred in 100% of the population. Having multiple victims and escalating the offense occurred in over 80% of the population. Offenders were least likely to use a weapon or inflict discernible harm.

3. Does the program serve juveniles who have a need to be in nonsecure residential treatment?

The weighted need for the pilot program was .60, suggesting moderate need. Table F.2 shows the percentages of charts with each of the need characteristics.

4. What need characteristics describe the population?

Table F.2 illustrates that 100% of the population had documented behavioral and emotional problems, 75% had a victim in the home and offended in proximity to parents, and 33% had a history of prior treatment and continued to reoffend.

5. What mental health problems describe this population?

Table F.3 depict the mental health problems. The four highest diagnoses include conduct disorder (67%), mood disorder (50%), ADHD (33%) and learning disorder (33%).

6. Are proper assessment practices being followed in identifying the population, including a Sex Offender Specific Assessment and a Sex Offender Specific Staffing?

The data show that 17% of the population had Level A assessments, and 100% of the population had Level B assessments.

Table F.1

Risk Characteristics

Used weapon	Inflicted discernible harm	Escalated offense	Used force	Multiple victims	Groomed victim	Repeated sexual assault cycle	Victimized peer
8%	8%	83%	25%	92%	100%	100%	25%

Table F.2

Need Characteristics

Prior treatment and continues to offend	Victim in Home	Has documented behavioral and emotional problems
33%	75%	100%

Table F.3

Mental Health Problems

ADHD	Adjustment	Anxiety	Conduct	Elimination	Impulse	Learning
33%	0%	25%	67%	17%	8%	33%

Mental Retardation	Mood	Features of Personality	Schizophrenia/ Psychosis	Substance	Seizure
8%	50%	17%	8%	8%	8%

Intake Criteria and Process

1. What is the extent of the program's compliance with Medicaid intake procedures ?

The program's implementation index was .80.

Treatment Constellation

1. Have youth signed a treatment plan?

Ninety-two percent of the youth signed a treatment plan.

2. To what extent do youth and line staff understand the content, depth, and breadth of the youth's treatment plan?

The youth in the pilot program understood a content of 3 words, a depth of 2 treatment goals, and a breadth of 2 treatment categories. The line staff understood an average content of 10 treatment words, 4 treatment goals, and 4 treatment categories.

3. What is the extent to which the treatment goals for the youth meet the minimum requirements of National Adolescent Perpetrator Network (1993) and NOJOS (1996)?

Table F.4 illustrates that no treatment goals dealt with reducing deviant arousal. Ninety-two percent of the charts had goals of remediating cognitive distortions. One hundred percent of the charts had goals dealing with the remaining subjects.

4. What is the extent of the program's compliance with Medicaid treatment planning procedures?

The program had 98% compliance with Medicaid treatment planning procedures. The only discrepancy was that one chart lacked a signature and credentials.

5. Does program have a master therapy manual?

Yes, the program has a master therapy manual.

6. Does family therapy meets contractual and NOJOS (1996) requirements?

There was a 92% compliance rate with this item. One chart did not have a goal of family therapy in the treatment plan.

7. Is a quarterly summary of treatment plan sent to DCFS or DYC?

8. Does group therapy meets NOJOS (1996) and DHS Contract requirements?

Group therapy implemented NOJOS and DHS Contract requirement at 100%.

9. Does individual therapy meets NOJOS (1996) and DHS Contract requirements?

Individual therapy complied in the number of meetings per week. However, individual therapy did not serve as supplemental, but rather as primary to group therapy.

Table F.4

Treatment Goals

Remediating cognitive distortions	Reducing deviant arousal	Relapse prevention	Healing personal victimization	Increasing interpersonal competency	Increasing personal competency	Decreasing exploitative behaviors
92%	0%	100%	100%	100%	100%	100%

Seventy-five percent of the charts indicated that a quarterly summary had been sent.

10. What is the extent to which the provision of adjunctive therapy modalities meets contractual and NOJOS (1996) requirements?

The program complied with all adjunctive therapies.

11. What is the extent to which life skills training/day treatment meets contractual and NOJOS (1996) requirements?

The pilot program met all life skills training requirements.

12. What is the extent to which recreational activities meet contractual and NOJOS requirements?

The pilot program met all recreational activities.

13. What is the nature of youth's educational placements?

Six of the youth were in Youth-In-Custody and six youth were in Special Education. All 12 of the youth were in an accredited program.

14. What is the extent to which client staffings meet contractual requirements?

Client staffings were held weekly, but DCFS and DYC were not invited to two staffings per month.

Supervision

1. Do staff to client ratios conform with contractual requirements?

There was 100% implementation in the pilot program, as the program both had 24 hour

awake supervision and a 1:3 staff to client ratio during the day.

2. To what extent to which the facility's composition comply with contractual requirements?

The pilot program's implementation index was .75. Problem areas included inadequate square footage per bedroom and lack of ventilation in some sleeping and bath areas.

3. To what extent does the program's monitoring system meet good practice standards?

The program met all three monitoring system requirements at 100% implementation.

4. Does the program have a written supervisory structure (system) that conforms with contractual requirements?

The program's written supervisory structure conformed 100% with contractual requirements.

5. Are program rules defined in a way that protect youth and the public? Implementation for the programs and for the group will be reported.

The program had 86% compliance. The only problem area was that room assignment was based on clinical decision. There was no written policy on room assignment.

6. To what extent do the line workers understand program rules?

The line workers listed an average of 1.3 bedroom rules, .33 bathroom rules, and 2.67 interpersonal rules.

7. To what extent do the youth understand written program rules?

The youth listed an average of 1 bedroom rule, 1 bathroom rule, and 1.22 interpersonal rules.

8. To what extent do youth understand rules that are taught by the line staff?

The youth matched the line staff an average of 1 time each for bedroom rules, 1.11 bathroom rules, and .89 interpersonal rules.

9. Are there rules about home visits that are designed to inhibit further offending behaviors?

The program complied.

10. To what extent does the program's violation process comply with NOJOS (1996) and DHS contractual requirements?

The program complied.

Aftercare

1. To what extent of the "continuum of care" concept does the program employ in planning for aftercare?

The program complied at a rate of 50%. The program did not have Level Two step- down programming, group aftercare, or extend aftercare for at least 6 months after completion of program.

2. What is the extent to which the program documents the aftercare plan?

The implementation rate was 75% because the program did not collaborate on the aftercare plan with DCFS/DYC.

3. What is the extent of the program's involvement in monitoring their efficacy through recidivism tracking?

The program did not monitor the rearrest and reoffense records of their former clients.

Staff Qualifications and Training

1. What is the extent to which the therapists employed by program are qualified as sex offender specific therapists?

The program's implementation rate was 80%. The program did not track the clinical hours of supervision of the therapist. Rather, the program expected the therapists to track their own hours.

2. What is the extent to which the line staff employed by programed are qualified as sex offender specific staff?

The program fully complied with the requirements for line staff.

3. What is the extent to which the line staff employed by program have been trained as sex

offender-specific staff?

The program complied at 50%. The staff was not trained in adolescent behavior and development, parenting skills, court procedures, the supervision of juveniles offending sexually, or treatment modalities.

Appendix G

ANOVA Data

TableG.1

Analysis of Variance of Risk Items

		Between groups		Within groups	
Source	F	df	M^2	df	M^2
Risk items	3.75	6	.71	43	.19

Table G.2

Analysis of Variance of Programs on Specific Characteristics

		Between groups		Within groups	
Source	F	df	M^2	df	M^2
Programs on "used force"	3.54	6	.44	43	.12
Programs on "peer victim"	3.75	6	.71	43	.19

Table G.3

Analysis of Variance of Need Items

		Between groups		Within groups	
Source	F	df	M^2	df	M^2
Need items	9.63	2	1.72	147	.18

Table G.4

Analysis of Variance of Mental Health Diagnoses

		Between groups		Within groups	
Source	F	df	M^2	df	M^2
Diagnoses	15.43	12	2.18	637	.14

Table G.5

Analysis of Variance of Programs on Specified Diagnoses

	Between groups			Within groups	
Source	F	df	M^2	df	M^2
Programs on "sexual disorders"	5.4	6	.75	43	.14
Programs on "features of personality disorders"	3.89	6	.73	43	.19
Programs on "conduct disorders"	4.77	6	.81	43	.17
Programs on "impulse disorders"	14.70	6	1.18	43	.08
Programs on "mood disorders"	4.47	6	.65	43	.14

Table G.6

Analysis of Variance Between Types of Abuse Experiences

	Between groups			Within groups	
Source	F	df	M^2	df	M^2
Abuse experiences	9.23	2	2.05	147	.22

Table G.7

Analysis of Variance Between Relationships of Offender's Perpetrator to the Offender

	Between groups			Within groups	
Source	F	df	M^2	df	M^2
Relationship	13.59	4	2.47	245	.18

Table G.8

Analysis of Variance of Programs on Variable "Mother as Perpetrator"

		Between groups		Within groups	
Source	F	df	M^2	df	M^2
Programs on "mother as perpetrator"	3.43	6	.52	43	.15

Table G.9

Analysis of Variance of Programs on Variable, "Gender of Victim"

		Between groups		Within groups	
Source	F	df	M^2	df	M^2
Programs	31.9	2	4.94	147	.15

Table G.10

Analysis of Variance of Programs on Variable, "Peer-age Victim"

		Between groups		Within groups	
Source	F	df	M^2	df	M^2
Programs	3.7	6	.71	43	.19

Table G.11

Analysis of Variance Between Relationships of Offender to His Victim

		Between groups		Within groups	
Source	F	df	M^2	df	M^2
Relationships	33.64	3	4.19	196	.12

Table G.12

Analysis of Variance Between Programs on Variable "Combination of Family, Acquaintences, and Strangers"

		Between groups		Within groups	
Source	F	df	M^2	df	M^2
Programs on "combination of family, acquaintences and strangers"	3.37	6	.61	43	.18

Table G.13

Analysis of Variance Between Categories of Treatment Goals

		Between groups		Within groups	
Source	F	df	M^2	df	M^2
Category of treatment goal	30.91	6	4.63	343	.15

Table G.14

Analysis of Variance Between Programs on Specified Treatment Goals

		Between groups		Within groups	
Source	F	df	M^2	df	M^2
Programs on "reducing deviant arousal"	6.74	6	.85	43	.13
Programs on "relapse prevention	12.55	6	1.11	43	.09
Programs on "personal competency"	10.02	6	5.88	43	.10
Programs on "reduce exploitative behaviors"	5.94	6	.91	43	.15

Vita

of

Katrina Holgate Miller

Work Experience

Division of Child and Family Services, Murray, Utah 09-95 to present

Position: *Licensed Clinical Therapist (Marriage and Family Therapist)*

Intensive family preservation with high-risk families involved in child sexual and physical abuse or neglect, gangs, or delinquency.

Jordan Valley Counseling Clinic, West Jordan, Utah 03-81 to 06-95

Position: *Marriage and Family Therapist*

Private practice therapy, including families, couples, individuals, and groups. Groups included stress reduction and smoking cessation.

Utah State University Extension Program, Ogden, Utah

01-93 to 03-95

Position: *Instructor*

Instructed an introductory marriage and family class to Job Corps young adults attending Utah State University.

Tooele Health and Human Services, Tooele, Utah 03-86 to 06-87

Position: *Social Service Worker 21*

Duties focused on investigation of welfare fraud. Support areas included the adversarial

counseling of fraud suspects and the preparation of their cases for administrative hearings or termination of entitlement.

Education

Utah State University, Logan, Utah
Major: *Family and Human Development* ***Ph.D.*** *Program,* Graduation: Summer 1997

Utah State University, Logan, Utah
Major: *Family and Human Development,* ***M.S.***, Graduation: 1979

Brigham Young University, Provo, Utah
Major: *Psychology,* ***B.S.***, Graduation: 1977

Licensure

Licensed Marriage and Family Therapist, State of Utah 1987 to present